

*Ethics*  
**IN**  
**PSYCHOTHERAPY**  
**AND**  
**COUNSELING**

**6<sup>th</sup>**  
Edition

**A PRACTICAL GUIDE**

Kenneth S. Pope  
Melba J. T. Vasquez  
Nayeli Y. Chavez-Dueñas  
Hector Y. Adames

**WILEY**

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# CRITICAL PRAISE FOR ETHICS IN PSYCHOTHERAPY AND COUNSELING

(Continued from the outside back cover)

*“Ethics in Psychotherapy and Counseling* has always been the volume I turn to when confronted with a complex risk management question with ethical implications. It has never let me down. As changes in technology and the changes in the health care system precipitated by the Affordable Care Act, HIPAA, and the rapid growth of telepsychology generated by the COVID-19 pandemic, mental health professionals will be confronting, with little guidance, unique problems with considerable ethical ambiguity. In this time of rapid change, this comprehensive but down to earth [6th edition] will become an even more essential resource.”

—**Eric Harris, JD, PhD**, Risk Management Consultant, The Trust  
(formerly American Psychological Association Insurance Trust)

“If you’re one of the tens of thousands of psychologists who already own previous editions of this iconic volume, get the new version without delay. Pope, Vasquez, Chavez-Dueñas, and Adames have more than updated the previous edition: their new material on two topics of importance to psychology—social justice and Telehealth—have earned it a spot in every psychologist’s library.”

—**Douglas C. Haldeman, PhD**, John F. Kennedy University

“The 6th edition is a compassionate, must-have resource for both students and seasoned professionals. Its emphasis on the importance of self-knowledge, moral courage, humility, cultural awareness, and sound ethical reasoning makes a significant contribution to our understanding of what it means to be ethical.”

—**Carole Sinclair, PhD**, Member and former Chair, Committee on  
Ethics, Canadian Psychological Association

“One of the most impressive aspects of the most recent edition of this book, the original of which was published in the last century, is the clarity, thoroughness, and compassion with which the authors

respond not only to the traditional ethical dilemmas confronted by psychologists and counselors, but also the speed with which they rise to the occasion of new challenges and quandaries. From who else would we have expected to see an ethics book that already engages in a thorough, informative, and socially just discussion of the question of on-line delivery of services in the COVID era than from these authors? I have counted myself fortunate to have always had their sage counsel in writing at my side throughout the more than forty years of my own career. All practicing therapists need to own and read this book, and it makes a timely addition to the reading list for an ethics class in this new decade, already replete with conundrums that no therapist from my cohort trained in the 1970s could have possibly imagined.”

—**Laura S. Brown, PhD, ABPP**, Psychotherapy Consultant and Forensic Psychologist in Private Practice, Seattle WA, and Clinical Professor, Department of Psychiatry and Behavioral Sciences, University of Washington

“In this best-in-show textbook, Pope and Vasquez have added two co-authors (Chavez-Dueñas and Adames) to the 6th edition, to provide a practical guide to ethics in psychotherapy and counseling. In a changing world beset by a pandemic and the need for new approaches to social justice, where Zoom calls, FaceTime, and other innovations challenge the field, this book will be an essential guide for the therapist and clinical researcher.”

—**Patrick O’Neill, PhD**, Professor Emeritus of Psychology (Acadia); Former President of the Canadian Psychological Association

“The 6th edition offers masterful guidance on ethical dilemmas, self-reflective critical thinking, blind spots, challenges of a pandemic, and the migration to videoconference treatment, and more. The authors parse culture and context, as well as human rights and addressing oppression in psychotherapy. All of it leads us further down the road toward social justice and improved health care. What a feat!”

—**Carol D. Goodheart, EdD**, Former President, American Psychological Association

“With the addition of co-authors Nayeli Y. Chavez-Dueñas and Hector Y. Adames, the 6th edition of Kenneth S. Pope and Melba J.T. Vasquez’s outstanding book transports us into today’s ethical challenges and conundrums. The engaging format continues to educate us about traditional ethical concepts while encouraging us to examine, reflect, and question our own ethical awareness. The extensive contributions regarding working competently with clients in a culturally diverse society, moral distress, and the concepts of emotional competence and power are especially eye-opening. Readers are kept focused on challenging decision-making but also on who they are or should aspire to be as self-reflective, competent practitioners. But this book is not just for students. Indeed, it is a must-read for all providers of mental health services.”

—**Patricia Keith-Spiegel, PhD**, Past-Chair, American Psychological Association Ethics Committee

“The 6th edition of *Ethics in Psychotherapy and Counseling* updates and expands upon an established classic. It is an indispensable resource for clinicians of any discipline. This book’s engaging prose and straightforward styling will make it an easy read at your leisure, while its pithy examples and cultivated wisdom will make it your first stop in a crisis. Buy it now, and keep it where you’ll always be able to find it.”

—**Eric Y. Drogin, JD, PhD, ABPP** (Forensic), Harvard Medical School; Former Chair, American Psychological Association Committee on Professional Practice and Standards

“The turn of this decade has thrust mental health professionals into a new world of practice. The foundational concepts of ethical practice such as confidentiality, informed consent, and multiple roles are no longer enough. The extraordinary expectations for mental health professionals’ new level of competence have no template at this time. This text squarely hits the four uncharted areas in our new world of practice: (a) what mental health professionals need to know to ethically engage in remote practice/videoconferencing (e.g., apps, social media); (b) significant changes in the APA and Canadian Code of Conduct enacted in the last three years; (c) how to respectfully respond to and treat clients living in systemic oppression; and (d) how to culturally enact competency and social justice in your

practice. The fundamentals across research, practice, and training are also significantly revised. This text is unquestionably the cutting-edge primer for our new world of practice and is an essential companion for mental health professionals.”

—**Linda F. Campbell, PhD**, Professor, The University of Georgia

“Pope and Vasquez demonstrate why they are leading ethics scholars in the 6th edition of their book, *Ethics in Psychotherapy and Counseling: A Practical Guide*, by adding to the authorship of the book two outstanding ethicists, Nayeli Y. Chavez-Dueñas and Hector Y. Adames. The trilogies of pandemics, racism, and economic challenges made it necessary to change our approach to ethics. Pope, Vasquez, Chavez-Dueñas, and Adames add the pandemics, telehealth, hackers, cultural humility, and broad diversities to challenge the reader’s thinking on ethics, moral courage, and doing the right thing. This book goes to the head of the line in my new purchases. I will use the 6th edition in my classes and presentations!”

—**Rosie Phillips Davis, PhD, ABPP**, Past President, American Psychological Association; Professor, Counseling, Educational Psychology and Research

“The latest iteration of this must-read resource for psychotherapists and counselors now includes contributions by two new co-authors, broadening perspectives and providing expanded COVID-era content on serving clients in a politically volatile socially distant world. The 6th edition has increased attention to telehealth and on ethical practice in the context of hot social issues. Substantial new material addresses ethical practice across the full range of differences among people, social justice, human rights, and societal oppression arising from racism, religious prejudice, and sexism/heterosexism. This well-crafted resource provides an enhanced level of ethical awareness to both experienced and novice practitioners.”

—**Gerald P. Koocher, PhD, ABPP**, Senior Lecturer, Harvard Medical School Department of Psychiatry and Bioethics Center faculty member; former President, American Psychological Association.

“This impressive book is a superb resource on ethics in psychotherapy and counseling. In its 6th edition, expert practitioner-scholars Pope, Vasquez, Chavez-Dueñas, and Adames, expand psychotherapy ethics into an inclusive and multifocal field. A powerful blend of case scenarios, research findings, valuable theory, and practical responsibilities. I highly recommend this outstanding book to practitioners, researchers, students, and to interested members of the public.”

—**Lillian Comas-Díaz, PhD**, Clinical Professor, George Washington University Department of Psychiatry and Behavioral Sciences

“As the latest stop on the road of excellence that began at the first edition, in the 6th edition of the classic text the authors have massively updated this practical guide with notes on COVID, virtual psychology, ethics changes in clinical codes, and other developments. By adding two additional authors and three new chapters, this deeply thoughtful work continues to serve as a guide through tangled ethical dilemmas.”

—**Thomas G. Gutheil, MD**, Professor of Psychiatry, Harvard Medical School

“This extraordinary 6th edition by Pope, Vasquez, Chavez-Dueñas, and Adames continues their wonderful tradition of outstanding scholarship, day-to-day practicality, and responsiveness to the ever-changing health care environment, including the challenges of the COVID-19 pandemic, telepsychology practice, and interjurisdiction compacts. They nicely capture the manner in which clinicians of today must grapple with psychotherapy’s complex realities. Readily readable, brilliant, and inspirational.”

—**Pat DeLeon, PhD**, former President, American Psychological Association

“Voilà!! Pope and Vasquez and their insightful new co-authors, Drs. Chavez-Dueñas and Adames, share their layers of insight and wisdom that only come from years of both science and therapeutic practice. Their 6th edition continues to be the definitive source for understanding the increasingly complex nature of ethical decision-making in psychotherapy. This edition particularly addresses cutting

edge issues in the ethical landscape that have become ever more challenging, including the subtle and delicate nuances across cultures, contexts, and individual differences, with particular attention to race, gender, religion, and sexual orientation. This edition also discusses the nuances of ethical dilemmas related to the shifts in our cultural context, specifically the impact of the COVID-19. Moreover, the authors are to be commended for squarely promoting a social justice perspective within ethics with three totally new and outstanding chapters that provide in-depth discussions of ways of aligning our practice with social justice and human rights; issues that are too often overlooked or forgotten. Bravo to authors Pope, Vasquez, Chavez-Dueñas, and Adames on this excellent and timely contribution to our professional literature!!”

—**Puncky Heppner, PhD**, Distinguished Curators Professor  
Emeritus, University of Missouri

“The 6th edition has been impressively expanded and updated. Pope, Vasquez, Chavez-Dueñas, and Adames have combined their remarkable personal and professional experiences. Using a blend of case law, research evidence, and ethics principles, the authors comment on topics such as COVID-19 and ethics, language and ethics, and malpractice.”

—**Dick Suinn, PhD**, Former President, American Psychological  
Association

“The 6th edition of *Ethics in Psychotherapy and Counseling: A Practical Guide* has been updated from the earlier editions to include, among other additions, materials related to the COVID-19 pandemic with materials related to virtual sessions over Zoom, FaceTime, etc. Drs. Pope and Vasquez have been joined by Professors Nayeli Y. Chavez-Dueñas and Hector Y. Adames in producing this invaluable resource.”

—**David. H. Mills, PhD**, Former Director, American Psychological  
Association Ethics Office

“Pope, Vasquez, Chavez-Dueñas, and Adames’ foundational text guides us through an unflinching look in the mirror to wrestle with our ethical reflection. They do so with grace and caring, while holding to a fierce commitment to advancing social justice, and



honoring the interlocking complexities of culture, oppression, and power. Yet beyond a call for reflection, it is ultimately a call to action that empowers readers to translate an ethical code into a lifelong practice of ethics.”

—**Alvin N. Alvarez, PhD**, Dean, College of Health & Social Sciences, San Francisco State University

“Talk about timely! Drs. Pope, Vasquez, Chavez-Dueñas, and Adames have responded to a clarion call to provide leadership and guidance to practitioners of the healing arts whose expertise, grounded in sound ethical and legal judgment, will be tapped differently in this era of COVID-19, reawakened social protests, and appalling national leadership. This 6th edition represents a go-to reference for mental health professionals seeking calm in the storms of chaos, controversy, and confusion.”

—**William D. Parham, PhD, ABPP**, Professor, Counseling Program Director, School of Education Loyola Marymount University; Director, Mental Health and Wellness Program National Basketball Players Association (NBPA)

# **Ethics in Psychotherapy and Counseling**

## **A Practical Guide, Sixth Edition**

KENNETH S. POPE, PHD, ABPP  
MELBA J. T. VASQUEZ, PHD, ABPP  
NAYELI Y. CHAVEZ-DUEÑAS, PHD  
HECTOR Y. ADAMES, PSYD

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For everyone who did the right thing when it was hard, took great courage, or came at great cost. And for all those—like those children taken from their families and put in cages, some of whom will never see their families again—who suffered because of our failure to do the right thing, our willingness to be passive, enabling bystanders, our shrugging and turning away.

And for Karen Olio, the wondrous love of my life.

**—Ken Pope**

To all those mentors and ancestors upon whose shoulders I stand, many known and many more unknown; to colleagues, friends, clients, and students, from whom I continue to learn; to my extended family, especially my parents, Ofelia Vasquez-Philo and Joe Vasquez, Jr. who motivated not only their family members but others to pursue education and to engage in social justice advocacy; and especially to my spouse and best friend, Jim H. Miller, who has provided the most significant encouragement in my life.

**—Melba J. T. Vasquez**

To Black and Indigenous people who believe that a better world is possible and continue to fight for it. To Immigrants whose dreams and hopes cross borders and transform this land. Para mi mamá Delfina Chavez-Dueñas y mi familia inmigrante de quien aprendí a luchar, trabajar duro, y seguir adelante a pesar de la adversidad. Para ti Itzael, el regalo mas grande que me mandaron los dioses para hacerme sonreír.

**—Nayeli Y. Chavez-Dueñas**

To all those who live their truth in the midst of suffering and oppression.

To those committed to the lives and liberation of Black people.

To my mami, papi, mama, and chosen family ... ustedes son mi todo.

**—Hector Y. Adames**

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# THE AUTHORS

**KENNETH S. POPE** is in independent practice as a licensed psychologist. He has chaired the ethics committee of the American Psychological Association (APA) and the American Board of Professional Psychology (ABPP). He received the 2015 Canadian Psychological Association John C. Service Member of the Year Award.

**MELBA J.T. VASQUEZ** is a licensed psychologist in independent practice in Austin, Texas. She has served on various ethics committees and task forces and served as the 2011 President of the American Psychological Association.

**NAYELI Y. CHAVEZ-DUEÑAS** is a licensed psychologist and professor in Chicago, Illinois. She co-founded and co-directs the Immigration, Critical Race, And Cultural Equity (IC-RACE) Lab. She earned the 2018 Distinguished Citizen Psychologist Award from the American Psychological Association.

**HECTOR Y. ADAMES** is a licensed psychologist and professor in Chicago, Illinois. He co-founded and co-directs the Immigration, Critical Race, And Cultural Equity (IC-RACE) Lab. He has chaired the Committee on Ethnic Minority Affairs of the American Psychological Association.

# PREFACE

Welcome to the sixth edition! So much has changed since the 5th edition. The novel coronavirus (COVID-19) pandemic transformed—at least temporarily—psychotherapy and counseling from encounters primarily conducted in-person to virtual meetings convened over Zoom, FaceTime, and other video conferencing and digital tools. Creative innovation, surprising research findings, landmark legal decisions, demographic shifts, and new perspectives continue to bring change to psychotherapy and counseling, and to ethical standards, theory, and practice. To address these trends and changes, we’ve updated all the chapters in this new edition and have created some new chapters.

The authorship of this book has also changed. Ken Pope and Melba Vasquez co-authored the first five editions of this book, and they’re still here. For this sixth edition, they reached out to two distinguished colleagues, Professors Nayeli Y. Chavez-Dueñas and Hector Y. Adames, both of whom are also licensed practitioners. Both Nayeli and Hector agreed to sign on as co-authors with Ken and Melba. The sixth edition benefits from four very diverse perspectives and co-authors who worked collaboratively to create an edition that motivate us all to strengthen and inform our ethical awareness and sense of personal and collective ethical responsibility.

The poor, unloved preface achieved sad notoriety as the least read part of most books. We’ll keep this one short—limiting it to only a note on terminology. We hope the conciseness inspires you to read on, set yourself apart from the crowd, and gain elite status as a reader of the preface.

## A NOTE ON TERMINOLOGY

This book discusses the varied and complex ethical issues that confront psychologists working as psychotherapists, other kinds of therapists (e.g., behavior therapists), and counselors. For brevity and convenience, we often use just one of these terms—rather than some

hyphenated form of all three—in a sentence. Similarly, some therapists identify those to whom they provide services as clients; others use the term patients. Again, for brevity and convenience, we have used these terms interchangeably throughout the book.

# ACKNOWLEDGEMENTS

We are deeply indebted to all those who contributed directly or indirectly to this book. We are grateful to all but have space to mention only a few. Emil Rodolfa, Ray Arsenault, Linda Campbell, Ursula Delworth, Barry Farber, Lisa Grossman, Kate Hays, Loralie Lawson, Karen Olio, and Janet Sonne are among those who read drafts of the current or previous editions and offered valuable suggestions for improvements.

We asked a number of prominent therapists with expertise in recognizing and responding to suicidal risk to discuss pitfalls of work in this area. [Chapter 22](#) presents the advice that each of these experts gives to readers. We thank those who contributed discussions: David Barlow, Danny Brom, Chris Brownson, Marla Craig, Jessica Henderson Daniel, Norman Farberow, the late Erika Fromm, Rosa Garci-Peltoniemi, Jesse Geller, Judith Lewis Herman, Don Hiroto, Maryam Jernigan-Noesi, Nadine Kaslow, the late Helen Block Lewis, Marsha Linehan, Ricardo Munoz, David Rudd, Gary Schoener, Shweta Sharma, and Danny Wedding.

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# **Part I**

## **FOUNDATIONS**

# Chapter 1

## HELPING WITHOUT HURTING

Psychotherapy holds out the promise of help for people who are hurting and in need. It can save lives and change lives. In therapy, clients can find their strengths and sense of hope. They can change course toward a more meaningful and healthy life. They can confront loss, tragedy, hopelessness, and the end of life in ways that do not leave them numb or paralyzed. They can discover what brings them joy and what sustains them through hard times. They can begin to trust, or to trust more wisely. They can learn new behaviors in therapy and how to teach themselves new behaviors after therapy ends. They can question what they always believed was a given. They can find out what matters most to them, and how to stop wasting time. They can become happier, or at least less miserable. They can become better able, as Freud noted, to love and to work. They can learn how to accept and love themselves just as they are and accept others who are different from them.

Our ethics acknowledge and affirm our profession's responsibilities. This book was written to help strengthen, deepen, and inform ethical awareness and the sense of personal ethical responsibility. Its job is to help you hold onto the ideals—including ethical ideals—that called you into the profession to begin with, to help you develop and fulfill those ideals. There will be so much—trust us on this—that tends to dull ethical awareness, to make ethics drift out of focus, to create barriers between you and your ideals, to replace ethics with pseudo-ethics and ethics placebos. Fatigue, endless paperwork, unrealistic expectations, illness, family crises, not being able to make ends meet, burnout, threats of job loss, insurance coverage that doesn't come close to meeting the needs of our clients, biases that have not been addressed, and so many other forces can pressure us into cutting ethical corners. This book is intended to help you develop a strong and healthy resistance to such forces, to help you weather them without losing your ethical awareness and ideals.

We can often help, but if our ethics slip, we can needlessly hurt. Mishandled, the process of therapy and counseling can waste time and opportunity. It can betray clients' hope, good faith, hard work, and trust. It can leave them worse off than before they reached out for our help. It can erode trust in the health system and prevent people from seeking help in the future.

Realizing how much our ethical decisions can affect the lives of those who come to us for help is central to our ethical awareness. What we do can make a difference in whether a client loses hope and commits suicide or chooses to live, whether a battered partner finds shelter or returns to a toxic and dangerous relationship, whether a teenager with anorexia gets help or starves to death. Such stark examples tell only part of the story. So many people come to us facing what seem to be minor, hard-to-define problems, yet the hard, risky, unpredictable twists and turns of their therapy can lead to more meaningful, effective, and fulfilling lives.

Few therapists take these responsibilities lightly. Few forget about a suicidal client between sessions. Few sit unmoved while a client talks, perhaps for the first time, about what it was like to survive an atrocity. Few turn away untroubled when a managed care company refuses to authorize treatment for someone in desperate need of help, someone who lacks enough money to put food on the table, let alone to pay for therapy.

Recognizing these responsibilities as they appear in our day-to-day work and deciding how to respond can be stressful, sometimes overwhelming. We may feel short of time, resources, or wisdom. We may feel pulled in different directions, stretched to or beyond the breaking point. The responsibilities can weigh us down, make us feel discouraged, rattle us, and make us want to run and hide. They can make us more vulnerable to other sources of stress and leave us prone to make flawed ethical decisions.

Uncertainty causes stress for some of us. We can't find that magical book that will tell us what to do, especially in a crisis. Research, guidelines, manuals, our own experience, and consultation help, but we can't know the best course in all situations, or even how the "best" course will turn out. We are constantly thrown back on our own judgment. If we believe a client *might* kill someone but there is no

explicit threat or other legal justification under the state's law to hospitalize the client or breach confidentiality, what do we do? What diagnosis should we write down if we know that the insurance company won't cover treatment for the client's condition and believe that the client's need for treatment is urgent, a matter of life or death? Will using stress-reducing imagery techniques help a client (reducing stress and increasing the client's effectiveness) or cause harm (enabling the client to adapt to an abusive job or relationship) is a question without an instantly clear, infallible answer. Does informed consent make sense if all it accomplishes is to cause a patient to turn away from life-saving treatment or stop them from sharing information critical to their treatment? The inescapable responsibility of making careful, informed professional judgment regarding issues of enormous complexity and potentially life-and-death implications can push even the most resourceful therapists to and beyond their limits.

Fearing that formal review agencies will hold us accountable, after the fact, scares, stresses, and distresses some of us. Some agencies focus specifically on the ethical aspects of our work. Others, such as state licensing boards and the civil courts, enforce professional standards of care that may reflect ethical responsibilities. The prospect of review agencies second-guessing us—and perhaps falling prey to both outcome bias and hindsight bias—can make difficult judgments a nightmare for some therapists. They may suffer debilitating performance anxiety, dread going to work, and discover that the focus of their work has changed from helping people to avoiding a malpractice suit.

Managed care stresses some therapists. For example, capitation contracts provide a limited sum of money to cover all services for a group of patients (e.g., a business that has contracted coverage for its employees with an agency). The agency providing services, having estimated the average number of sessions needed for each patient, must limit the total number of sessions to make a profit. Strict guidelines may limit how many sessions a therapist can provide. Therapists may feel pressure to terminate before the limit, even if they think services are still needed. Even if clinicians follow agency procedures, they may face charges before an ethics committee, licensing board, or malpractice court for patient abandonment,



improper denial of treatment, or similar issues. Therapists may fear not only that a formal review agency will sanction them but also that the limited sessions fall far short of what their clients need.

Teaching or learning therapy is practiced on the living—this can stress us. As supervisors, we may grow uncomfortable with how the supervisee responds to the client differently from how we would, with our responsibility to evaluate the supervisee's work, and with the demands of our role as teacher, mentor, and gatekeeper. As supervisees, we may doubt our ability to carry out clinical responsibilities (especially when they involve suicidal or homicidal risks), dread making mistakes, feel uneasy about differences in values or theoretical orientation between ourselves and our supervisor, wonder if racial (or gender or sexual orientation or religious or political, or, or, or) differences between us and our supervisor are causing us to be viewed in a negative light, and figure that if we are completely honest in describing to our supervisor what we actually thought, felt, and did with our clients, we might be advised to look for another line of work.

Learning to work competently with clients from various identity groups can be challenging. Understanding and integrating racial and cultural issues and context is fundamental to our professional responsibilities. We can complete workshops, read, get supervision, take continuing education courses, but the challenge in gaining knowledge about various social groups will be an ongoing task. Knowledge about the various social identities that our clients represent will be necessary in assessing the degree to which we integrate various values, behaviors, and expectations in the course of treatment. Those potential identities include but are not limited to race, ethnicity, generation, gender, ability status, sexual orientation, gender identity, caste, religion, spirituality, immigration, employment, and the like. Working competently requires awareness, knowledge, and skills about people's identities and the ways in which overlapping forms of oppression (e.g., gendered-racism, gendered anti-Semitism) impact people's lives (for further reading on the theory of intersectionality as originally created by Black Women see Combahee River Collective, 1995; Crenshaw, 1991; for intersectionality in clinical practice see Adames et al., 2018; Chavez-Dueñas et al., 2019).

## WHAT DO I DO NOW?

A fundamental stress that confronts therapists is the urgent, complex, inescapable question: “What do I do now?” Consider these scenarios:

- I’m staring at this insurance form, wondering if I should get creative with the diagnosis. They won’t cover this new patient’s condition, but they can’t get the help they desperately need without the coverage.
- Thought I’d hit the jackpot when my new grad school therapy supervisor turned out to be nationally known and her recommendation to be key to the rest of my career, but she’s telling me to do things that are ethically shifty.
- She’s sitting here in front of me, crying and telling me I’m her last hope because her husband beats her, but there are no shelter beds open and she can’t go to the police because her husband is a decorated police captain.
- The physician down the hall is a quack, but as long as I refer my patients to him, he sends me enough referrals to pay my bills.
- My immigrant client is struggling to obtain a green card (residence card), and has been waiting a much longer than average time period. I have contacts in the agency. Should I intervene to help facilitate the process? Is this an act of appropriate social justice?
- A pregnant teenage client is considering having an abortion. She has not shared the news with her parents and wants me to keep her pregnancy a secret. She fears being kicked out of the house if her parents find out about her pregnancy.

Doing psychotherapy confronts us with constant challenges. Each ethical challenge, large or small, subtle or staring us in the face, brings a tangle of questions. Is there a “right” thing to do? If so, how do I find out what it is? How do I actually go about doing it? What makes it right? Who says so? If I do it, what will happen to the patient? to me? to innocent—and not-so-innocent—bystanders?

We wrestle with personal questions that are hard to admit to ourselves or others. What am I tempted to do? What could I get away with? Would doing the right thing cost too much? make people mad at me? get me sued? get me fired? Would doing the wrong thing be all that bad? Would anyone find out? What would happen to me if they did? What if I'm not strong enough, not "good" enough to do the right thing? Can I duck this one and stick someone else with it?

These stinging questions always lead back to the basic question: What do I do now?

Strong, deep, informed ethical awareness helps us answer that question. It brings into focus how our choices affect the lives of our patients, our colleagues, and the public. It frees us from the sticky webs of habit, fatigue, fallacy, dogma, carelessness, hurry, and stress. It wakes us to new possibilities.

If this book helps you to strengthen, deepen, and inform your ethical awareness, it will help you find better answers to that basic question: What do I do now? This book will disappoint those looking for an ethics cookbook, an authority pointing out the right answer for every scenario, a substitute for ethical consideration, decision-making, and personal responsibility. We believe that approach fails in the real world, leading us to blunder with confidence.

Each of us must bring our own ethical awareness to the challenges, pitfalls, and opportunities that we face in each unique, constantly changing situation, to make the best choices. We emphasize eight basic assumptions about ethical awareness.

1. Ethical awareness is a continuous and active process that involves constant questioning and personal responsibility.

Our work requires constant alertness and mindful awareness of the ethical implications of what *we* choose to do and not do. Ethical awareness helps us to shoulder personal responsibility for our ethical choices, for what we choose to do and not do. We face the consequences for what we choose or not choose to do.

Ethical awareness helps us avoid quick certainties that shut down further questioning. It prompts us to rethink what seems to be a “given,” to continuously look for more creative, more ethical, more effective solutions to problems.

Ethical awareness means setting aside arrogance and complacency. All of us have weaknesses, vulnerabilities, and blind spots—it comes with being human. The stark differences are not so much between those with many flaws and those with few but between those who are freely open to themselves and others about how their own shortcomings affect their work and those who tend to hide such shortcomings and see others as their inferiors.

Ethical awareness depends on our ability to take care of ourselves, to recognize when exhaustion, personal problems, or feelings like fear, anger, boredom, resentment, sadness, hopelessness, or anxiety hurt our work, and to do something about it.

2. Awareness of ethical codes is crucial, but formal codes cannot take the place of an active, thoughtful, creative approach to our ethical responsibilities.

Ethical awareness is strengthened and informed by pouring over the ethics codes that bear on our work. But formal standards and guidelines<sup>1</sup> are no substitute for an active, deliberative, and creative approach to our ethical responsibilities. Codes prompt, guide, and inform our ethical considerations; they do not shut it down or take its place.

Ethical awareness never allows us to follow a code in a rote, thoughtless manner. Each new client, whatever their similarities to previous clients, is unique. Each situation is unique and constantly changing—time and events never stand still. Our theoretical orientation, our community and the client’s community, our race and culture and the client’s race, culture, and so many other contexts and factors shape what we see and how we make sense of what we see. Each ethical choice must take these complexities and contexts into account.

Codes can steer us away from clearly unethical approaches. They can shine a light on key values and concerns. But they cannot tell us what form these values and concerns will take. Standards and guidelines can set forth essential tasks or point to aspirational goals but they never show us the best way to carry out those tasks and realize those goals with a unique client facing unique problems in a specific time and place with limited resources. Ethical decision-making is a process and codes are only one part of that process.

3. Awareness of laws is crucial, but legal standards should not be confused with ethical responsibilities.

A risk in the emphasis on legal standards is that meeting legal standards, which for some can mean finding ways around those standards (e.g., looking for loopholes), can start to replace ethical behavior. This practice is a high art in the political arena. Caught betraying the public trust, politicians often insist they did nothing wrong because no law was broken. When it turns out that a law *was* broken, politicians admit that their enemies are harping on a mere “technical violation of the law.” Ethical awareness avoids the comfortable trap of aiming low, of striving only to get by without breaking any law.

Ethical awareness stays alert to possible conflicts between our ethical and our legal duties.

An overly exclusive focus on legal standards discourages ethical responsibility. Practicing “defensive therapy”—making risk management our main focus—can cause us to lose sight of our ethical responsibilities and the ethical consequences of what we say and do. When we originally discussed this tendency to confuse legal and ethical issues over 30 years ago in this book’s first edition, the tendency had already begun to spread widely. It shows no signs of slowing down.

4. We believe that the overwhelming majority of therapists and counselors are conscientious, dedicated, caring individuals, committed to ethical behavior. But none of us is infallible.

All of us can—and do—make mistakes, overlook something important, work from a limited perspective, reach conclusions that are wrong, hold tight to cherished beliefs that are misguided or biased. We're aware of many barriers between us and our best work, but we may underestimate or overlook some of those barriers. Part of our responsibility is to question ourselves: What if I'm wrong about this? Is there something I'm overlooking? Could there be another way of understanding this situation? Are there other possibilities? Can I come up with a more creative, more effective, better way of responding?

5. Many of us find it easier to question the ethics of others than to question what we ourselves value, believe, and do. It is worth noticing if we often find ourselves stewing over just how ethically weak, dense, or shady others are while sparing ourselves from critical self-assessment.

It is a red flag if we spend more time trying to point out other people's weaknesses, flaws, mistakes, ethical blindness, destructive actions, or hopeless stupidity than we spend questioning and challenging ourselves in positive, effective, and productive ways that awaken us to new perspectives and possibilities. Questioning ourselves is at least as important as questioning others.

6. Most of us find it easier to question ourselves on those intriguing topics we know we don't understand, that we stumble onto with confusion, uncertainty, and doubt. The harder but more helpful work is to question ourselves about our casual certainties. What have we taken for granted and accepted without challenge? Nothing can be placed off limits for this questioning.

Certainties are hard to give up, especially when they feel like they are part of who we are. They become landmarks, helping us make sense of the world, guiding our steps. But perhaps an always-reliable theoretical orientation begins distorting our view of a new patient, leading us to interventions that make things worse. Or having always prided ourselves on the soundness of our psychological evaluations, we keep rereading our draft report in a case in which an unbiased

description of our findings may bring about a tragic injustice, harming many innocent people, and begin to wonder if our feelings for the client led us to shade the truth. Or the heart of our internship has been the supervision, and we've made it a point to tell the supervisor everything important about every patient, except about getting so turned on with that one patient, the one who is not very vulnerable at all and does not really need therapy, the one we keep having fantasies of asking out after waiting a reasonable time after termination and then, if all goes well, proposing to.

Questioning our certainties means actively and repeatedly seeking out and listening respectfully to those who disagree with us and engaging them in openly exchanging views. It means actively searching out articles and books that challenge—and sometime attack—our assumptions, beliefs, and practices.

We must follow this questioning wherever it leads, even if we venture into territories that some might view as politically incorrect or—much harder for most of us—“psychologically incorrect” (Pope et al., 2006).

7. We often encounter ethical dilemmas without clear and easy answers.

As we try to help people who come to us because they are hurting and in need, we confront overwhelming needs unmatched by adequate resources, conflicting responsibilities that seem impossible to reconcile, systems that work against the best interests of our clients, frustrating limits to our understanding and interventions, and countless other challenges. We may be the only person a desperate client can turn to, and we may be jerked every which way by values, events, limited time, and limited options. Our best efforts to sort through such challenges may lead us to a thoughtful, informed conclusion about the most ethical path that is in stark contradiction to the thoughtful, informed conclusions of a best friend, a formal consultant, our attorney, or the professional groups we belong to.

In the midst of these limitations, conflicts, disagreements, and complexities, we must make the best choices we can. We must each

struggle to answer the question: What do I do now? And each of us must take responsibility for the decisions we ultimately make. We cannot shift personal responsibility for what we decide and what we do to another person, group, law, code, or custom. There is no escape from these struggles. They are part of our work.

8. We and our clients do not live in a vacuum. We live and develop in sociocultural contexts.

We are called to act in accordance with an ethic of human rights and social justice. We open our eyes and hearts to how discrimination, hatred, injustice, beatings, xenophobia, slavery, jail, starvation, torture, or genocide—based on factors like race, religion, immigration, culture, gender, sexual orientation, disability, politics—affect us, our clients, their families and communities, our supervisees, and the world we live and work in. We search for the most ethical response to social injustice. We don't shrug our shoulders and turn away. We face these issues with courage, honesty, caring, and a sense of personal responsibility to respond ethically.

## Notes

- <sup>1</sup> Professional standards are considered to be mandatory while guidelines are aspirational in intent and highly recommended for best practice.



# Chapter 2

## ETHICS IN REAL LIFE

Even the simplest ethical concept, standard, or guideline can fool us. We hear it in class. We read it in the code. We understand it. We can explain it in a test, give a lecture on it, or explain it to a jury. We know the concept, standard, or guideline, but it fools us when it shows up unexpected in the messiness of real life. It comes dressed in different clothes—and sometimes camouflage—and we don't recognize it.

Therapy offers countless challenges to recognizing how a specific ethical concept, standard, or guideline might be helpful or vital. One reason is that concepts, standards, and guidelines tend to be abstract, general, and sometimes ambiguous. Another reason is that psychotherapy can be such a complex set of interactions between unique people. Yet another is that psychotherapy can serve as the intense focus of need, hope, risk, and expectation. Lives can be at stake.

In the midst of this work, as it actually happens in real life, it can be hard to recognize those moments when we need to consider an abstract ethical concept, standard, or guideline.

This chapter provides examples of those moments as they happen in the messy textures of real life. None is based on a specific case (and none of the people are based on an actual clinician or patient), but each represents the kinds of challenges that therapists and counselors face in their day-to-day practice.

In each of the following fictional scenarios, the clinicians were trying to do their best. Readers may disagree over whether each clinician met the highest or even minimal ethical standards, and such disagreements can form the focus of classroom discussions, case conference presentations, or supervision consultation. In at least one or two instances, you may conclude that what the clinician did was perfectly reasonable and perhaps even showed courage and profound

ethical awareness. In some cases, you may feel that significant relevant information is missing. But in each instance, the professional's actions (or failures to act) become the basis of one or more formal complaints.

As you read each scenario, consider the situation from the point of view of each person mentioned as well as a member of an ethics committee, licensing board, or jury hearing the complaint.

## **RECORDS**

After a full day of Zoom and Facebook sessions with her clients, Dr. Soo sits down at the computer to update her clinical files, making sure all the notes, billing information, digital copies of the day's Zoom and Facetime sessions (recorded with the full informed consent of her clients), and other records are current. She turns on the computer and ... nothing. Just a blank screen. That's never happened before. Wait: A message scrolls into view:

Greetings, Dr. Soo! I was able to hack into your computer—obviously!—and copy all your files. Yes, even your video files, which I found quite interesting. I even accessed those files you stashed in the cloud as backups. Your passwords weren't much of a challenge for my software and finding your key to unencrypt your encrypted files was something I did while multitasking. I left your files on your computer, but I used a much more sophisticated program to encrypt them so that you can't access them.

I'll bet you're upset, even angry, but you needn't be. All can be set right as rain in just a step or two. All you need do is deposit \$25,000 U.S. in bitcoin into the account specified at the bottom of the page within 72 hours, I'll send you the key that will unencrypt your files, and you'll never hear from me again.

Easy, isn't it? A simple quid pro quo.

Oh, one more thing, Dr. Soo. What if you don't pay within 72 hours? What if you think you don't even *need* to pay because you've got another copy of all your records hidden somewhere on a disk that is not connected to the internet and so inaccessible to me and my merry band of fun-loving rascals? Well, you should know that were I not to receive the bitcoin within 72 hours—and I have full confidence you won't let that happen—unencrypted copies of all your files will start appearing on all sorts of anonymous websites, and your clients and all others in your address book will receive notification along with links to some of those websites.

In closing, allow me to wish you well, Dr. Soo, especially next Tuesday, where I see in your scheduler and notes you're expected to testify as an expert witness on the clinical records you reviewed and the tests you administered. It would be *such* a shame if the judge and attorneys in that case were to be notified before you testified that you had guarded the confidentiality of all those records so well that they were now available for all to see on a whole array of websites. Bet that would lead to an interesting cross-examination? Might even lead to a little chat with the licensing board.

Bye-bye, doc! And thank you for making me feel so welcome. No two-factor identification when signing in to your computer, no

ransomware protection, not even a virtual private network when you connect to the internet. I felt you were inviting me in.

To avoid having her clients' records and videos flashed across the web, Dr. Soo manages to get together \$25,000 by emptying her savings and borrowing the rest, and sends off the bitcoin under the deadline. However, the files are never returned to her—They show up on a variety of anonymous websites. Several clients sue.

## LUNCH

Josefina was a Black Cuban high school student. She worked part time as a cook. During the first session with Dr. Marcus she poured out a heart full of pain from the discrimination and racist abuse she'd endured at her mostly-White high school and at her job. Just being able to talk about it made her hurt less, she said. She didn't feel so suicidal as she had the last few weeks. The next session she showed up extremely distressed. She'd lost her job as a cook and could no longer pay for therapy.

Dr. Marcus, who did *pro bono* work conducting asylum assessments at a legal aid clinic, had never offered free therapy. He believed that patients would not value or work hard if therapy cost nothing. So, he suggested various ways they might barter for the fee. Josefina had nothing tangible to barter with but Dr. Marcus suggested that, since she had been a cook, if she were to cook him a meal and bring it with her to each session, he would accept that as payment. She gladly accepted, thrilled she'd be able to continue therapy.

After four more weekly sessions, Josefina failed to show up for her appointment. Instead Dr. Marcus was served notice of a malpractice suit filed by Josefina's parents. They alleged that he had taken advantage of and mistreated a minor. Josefina had been suffering from racial prejudice, discrimination, and abuse at her high school and job, and instead of respecting her and providing valid treatment, he had treated her in the most stereotypical manner possible and turned a minor into his personal maid, telling her she must bring him his lunch. Both the subsequent therapist and the expert witness hired by the family agreed that treating Josefina in this way was unethical and damaging.

## **THE MECHANIC**

Ms. Huang, whose family had moved from mainland China to the United States 15 years ago, is a 45 year-old automobile mechanic. She agreed, at the strong urging of her employer, to seek psychotherapy for difficulties that seem to affect her work performance. She has been showing up late at her job, has often phoned in sick, and frequently appears distracted. She complains to her new therapist, Dr. Jackson, of the difficulties she is having coping both with psychomotor epilepsy, which has been controlled through medication, and with her progressive diabetes, for which she is also receiving medical care.

Although she has no real experience treating people of Chinese descent or patients with chronic medical conditions such as epilepsy, Dr. Jackson begins to work with Ms. Huang. She meets with her on a regular basis for three months, but never feels that a solid working alliance is developing. After three months, Ms. Huang abruptly quits therapy. At the time, she had not paid for the last six sessions.

Two weeks later, Dr. Jackson receives a request to send Ms. Huang's treatment records to her new therapist. Dr. Jackson notifies Ms. Huang that she will not forward the records until the bill has been paid in full.

Some time later, Dr. Jackson is notified that she is the complaine in a licensing case and that she has been sued for malpractice. The complaints allege that Dr. Jackson had been practicing outside of her areas of competence because she had received no formal education or training and had no supervised experience in treating people of Chinese descent or those with multiple serious and chronic medical diseases. The complaints also alleged that Ms. Huang had never adequately understood the nature of treatment as evidenced by the lack of any written informed consent. Finally, the complaints alleged that "holding records hostage" for payment violated Ms. Huang's welfare and deprived her subsequent therapist of having prompt and comprehensive information necessary to Ms. Huang's treatment.

## **EVALUATING CHILDREN**

Ms. Cain brings her two children, ages four and six, to Dr. Durrenberger for a psychological evaluation. She reports that they have become somewhat upset during the last few months. They are having nightmares and frequently wet their beds. She suspects that the problem may have something to do with their last visit with their father, who lives in another state.

Dr. Durrenberger schedules three sessions in which he sees Ms. Cain and her two children together and three individual sessions with each of the children. As he is preparing his report, he receives a subpoena to testify in a civil suit that Ms. Cain is filing against her ex-husband. She is suing for custody of her children. During the trial, Dr. Durrenberger testifies that the children seem, on the basis of interviews and psychological tests, to have a stronger, more positive relationship with their mother. He gives his professional opinion that the children would be better off with their mother and that she should be given custody.

Mr. Cain files an ethics complaint, a civil suit, and a licensing complaint against Dr. Durrenberger. One basis of his complaint is that Dr. Durrenberger had not obtained informed consent to conduct the assessments. When Mr. and Ms. Cain had divorced two years previously, the court had granted Mr. Cain legal custody of the children but had granted Ms. Cain visitation rights. (Ms. Cain had arranged for the assessments of the children during a long summer visit.) Another basis of the complaint was that Dr. Durrenberger had made a formal recommendation regarding custody placement without making any attempt to interview or evaluate Mr. Cain. Additionally, Mr. Cain's attorney and expert witnesses maintained that no custody recommendation could be made without interviewing both parents.

## **STAYING SOBER**

In therapy for one year with Dr. Franks, Mr. Edwards experienced alcoholism and drank heavily for four years prior to therapy. Dr. Franks uses a psychodynamic approach but also incorporates behavioral techniques specifically designed to address the drinking problem.

Two months into therapy, when it became apparent that outpatient psychotherapy alone was not effective, Mr. Edwards agreed to attend Alcoholics Anonymous (AA) meetings as an adjunct to his therapy. During the past nine months of therapy, Mr. Edwards had generally been sober, suffering only two relapses, each time falling off the wagon for a long weekend.

Now, a year into therapy, Mr. Edwards suffers a third relapse. He comes to the session having just had several drinks. During the session, Dr. Franks and Mr. Edwards conclude that some of the troubling material that has been emerging in the therapy had led Mr. Edwards to begin drinking again. At the end of the session, Mr. Edwards feels that he has gained some additional insight into why he drank. He decides to go straight from the session to an AA meeting.

One month later, Dr. Franks is notified that he is being sued. On his way from the therapy session to the AA meeting, Mr. Edwards had run a red light and had killed a mother and her child who were crossing the street. The suit alleged that the therapist knew or should have known his patient to be dangerous since he was driving while inebriated, and should have taken steps to prevent him from driving that day, specifically, as well as until his alcoholism no longer constituted a danger to the public.

## **THE INTERNSHIP**

Dr. Larson is an executive director and clinical chief of staff at the Golden Internship Health Maintenance Organization. For one year, he closely supervises an excellent postdoctoral intern, Dr. Marshall. The supervisee shows great potential, working with a range of patients who respond positively to her interventions. After completing her internship and becoming licensed, Dr. Marshall goes into business for herself, opening an office several blocks from Golden Internship Managed Care Organization. Before terminating her work at the organization, Dr. Larson tells Dr. Marshall that she must transfer all patients to other center therapists. All of the patients who can afford her fee schedule, however, decide to continue in therapy with Dr. Marshall at her new office. The patients who cannot afford Dr. Marshall's fee schedule are assigned to new therapists at the center. Dr. Larson hires an attorney to take legal

action against Dr. Marshall, asserting that she unethically exploited the health maintenance organization (HMO) by stealing patients and engaging in deceptive practices. He files formal complaints against her with the state licensing board, charging that she had refused to follow his supervision in regard to the patients and pointed out that he, as the clinical supervisor of this trainee, had been both clinically and legally responsible for the patients. He refuses to turn over the patients' charts to Dr. Marshall or to certify to various associations to whom she has applied for membership that Dr. Marshall has successfully completed her postdoctoral internship.

Dr. Marshall countersues, claiming that Dr. Larson is engaging in illegal restraint of trade and not acting in the patients' best interests. The patients, she asserts, have formed an intense transference and an effective working alliance with her; to lose their therapist would be clinically damaging and not in their best interests. She files formal complaints against Dr. Larson with the licensing board, charging that his refusal to deliver copies of the patients' charts and to certify that she completed the internship violates ethical and professional standards.

Some of the patients sue the Golden Internship Managed Care Organization, Dr. Larson, and Dr. Marshall, charging that the conflict and the legal actions (in which their cases are put at issue without their consent) have been damaging to their therapy.

## **THE FATAL DISEASE**

When George, a 19 year-old college student, began psychotherapy with Dr. Hightower, he told the doctor that he was suffering from a fatal disease. Two months into therapy, George felt that he trusted his therapist enough to tell her that the disease was AIDS (acquired immune deficiency syndrome).

During the next 18 months, much of the therapy focused on George's losing battle with his illness and his preparations for the end of life. After two stays in the hospital for pneumonia, George informed Dr. Hightower that he knew he would not survive his next hospitalization. He had done independent research and talked with his physicians, and he was certain that, if pneumonia developed



again, it would be fatal due to numerous complications and that it would likely be a long and painful death. George said that when that time came, he wanted to die in the off-campus apartment he had lived in since he came to college—not in the hospital. He would, when he felt himself getting sicker, take some illicitly obtained drugs that would ease him into death. Dr. Hightower tried to dissuade him from this plan, but George refused to discuss it and said that if Dr. Hightower continued to bring up the subject, he would quit therapy. Convinced that George would quit therapy rather than discuss his plan, Dr. Hightower decided that the best course of action was to offer caring and support—rather than confrontation and argument—to a patient who seemed to have only a few months to live.

Four months later, Dr. Hightower was notified that George had taken his life. Within the next month, Dr. Hightower became the defendant in two civil suits. One suit, filed by George's family, alleged that Dr. Hightower, aware that George was intending to take his own life, did not take reasonable and adequate steps to prevent the suicide, that she had not notified any third parties of the suicide plan, had not required George to get rid of the illicit drugs, and had not used hospitalization to prevent the suicide. The other suit was filed by a college student who had been George's partner. The student alleged that Dr. Hightower, knowing that George had a partner and that he had a fatal sexually transmitted disease, had a duty to protect George's partner. The partner alleged ignorance that George had been suffering from AIDS.

## **LIFE IN CHAOS**

Mr. Alvarez, a 45 year-old professor of physics, has never before sought psychotherapy. He shows up for his first appointment with Dr. Brinks. He shares with Dr. Brinks that his life is in chaos. Dr. Brinks was granted full professor status about a year ago and about one month after that, his wife suddenly left him to live with another man. He became very depressed. About four months ago, he began to become anxious and to have trouble concentrating. He feels he needs someone to talk to so that he can figure out what happened. Mr. Alvarez and Dr. Brinks agree to meet twice every week for outpatient psychotherapy.

During the first few sessions, Mr. Alvarez says that he feels relieved that he can talk about his problems, but he remains very anxious. During the next few months, he begins talking about some traumatic experiences in his early childhood. He reports that he is having even more trouble concentrating. Dr. Brinks assures him that this is not surprising, that problems concentrating often become temporarily worse when a patient starts becoming aware of painful memories that had been repressed. She suggests that they begin meeting three times a week, and Mr. Alvarez agrees.

One month later, Mr. Alvarez collapses, is rushed to the hospital, but is dead upon arrival. An autopsy reveals that a small but growing tumor had been pressing against a blood vessel in his brain. When the vessel burst, he died.

Months after Mr. Alvarez's death, Dr. Brinks is served notice that the licensing board is opening a formal case against her based upon a complaint filed by Mr. Alvarez's relatives. Furthermore, she is being sued for malpractice. The licensing complaint and the malpractice suit allege that she was negligent in diagnosing Mr. Alvarez in that she had failed to take any step to rule out organic causes for Mr. Alvarez's concentration difficulties, had not applied any of the principles and procedures of the profession of psychology to identify organic impairment, and had not referred Mr. Alvarez for evaluation by a neuropsychologist or to a physician for a cognitive and medical examination.

## **LANGUAGE: THE INTERPRETER**

Angelica, who was born in Bolivia and migrated to the US two years ago, is a 55 year-old mother of three. Following the advice of her physician and sister, she decides to seek psychotherapy to deal with insomnia, lack of appetite, and uncontrollable crying spells. Angelica only speaks Spanish and there are no bilingual therapists available at the clinic; however, Dr. Jones agrees to work with Angelica. Wanting to help Angelica, Dr. Jones agreed to do therapy with an interpreter, although this is the first time she is providing therapy services with an interpreter. She is sure that all interpreters know what to do. Dr. Jones proceeds to schedule Angelic's intake. During the clinical interview Angelica seemed to be worried and went back and forth

with the interpreter. Dr. Jones, not speaking Spanish, is unable to follow what's happening and when she inquires, the interpreter only says that Angelica feels ashamed of speaking about her family's business. Dr. Jones, via the interpreter, tells Angelica not to worry and goes on to discuss informed consent and confidentiality. Angelica does not return to her second session and several months later, Dr. Jones receives a letter indicating that a civil law suit had been filed against her. According to the letter, Dr. Jones assured Angelica that all of the information that was shared in therapy would remain confidential, but somehow her husband, who has a long history of domestic violence, found out all of the details that Angelica disclosed to Dr. Jones during the intake interview. He became so violent toward Angelica that she spent several days in the intensive care unit (ICU) recuperating from the physical abuse.

## **COMPUTER COINCIDENCES**

What happened to these therapists was so traumatic that, even though they are fictional characters and never existed, they have fled into other lines of work, do not want to be recognized, and demand anonymity in this hypothetical scenario. The catastrophes seemed to start when one of them hit the "send" button on his computer.

For many years they had maintained a small and very successful group practice. Then they modernized, bringing in state-of-the-art computers, elegantly networked and equipped with wonderful software that made the therapists' work so much easier.

Until one day the first therapist hit the send button. He had carefully collected all the electronic records of one of his patients, who was involved in litigation, to e-mail to the patient's attorney. There were the billing records, results of psychological testing, records of therapy sessions, as well as the background records (employment, disability, etc.) that the therapist had on file. The therapist gave one last look and then hit the send button.

It was only after watching his computer send off the records that the therapist realized he had used the wrong address on the e-mail. The patient records were on their way, not to the patient's attorney, but to a large internet discussion list that the therapist belonged to. This

unfortunate series of events led to a formal complaint against the therapist.

By a far-fetched coincidence typical of hypothetical scenarios, the second therapist walked into the first therapist's office just when the first therapist was hitting the send button. Here's what the second therapist said: "Can you believe it!? I'm being sued, and it's all because of my computer! When my patient temporarily moved to the east coast for a sabbatical, we thought it best to continue treatment, but because of the time difference and our heavy schedules, we couldn't find a time when we could both talk, so we decided to communicate by e-mail. But then she got mad at me about something and filed complaints against me in the other state! So now they're saying I was providing psychological services in that state without being licensed in that state, and that I failed to follow that state's rules and regulations about...well you'd have to read the complaints her attorney has filed with the licensing board, the courts, and the ethics committee. It's terrible!"

As if sensing that another wild coincidence was needed to keep the story moving, the third therapist rushed into the first therapist's office at that moment and said: "You won't believe what just happened! I just got a formal notice that I'm being sued! I just found out what happened: Somehow a virus or Trojan or Worm or one of those things got into my computer and took my files—you know, all my confidential case files—and sent them to everyone listed in my address book and to all the other addresses in my computer's memory. What do I do now?"

On cue, the fourth therapist ran into the room and cried, "Help! I'm in such trouble! One of my patients is involved in a nasty law suit, and I received a court order to produce all my records. The patient had given me consent to turn them over because she and her attorney believe they will be the key to their winning the case. So, I sat down to print them out and ... they're gone! My hard drive crashed and when I hired a company to rescue what they could, they retrieved some of the files but all the files for that patient are gone. What do I do now?"

Although the room was getting crowded, the fifth therapist slouched in, collapsed in a chair, and said, "I'm doomed. I kept all my records

on my laptop. But while I was at lunch today, someone broke into my car and stole it. Then I got worse news. I thought at least the files would be safe because I encrypted them, but I just found out from a colleague that since the program I used to encrypt and unencrypt them is on that computer and since many thieves have software that enables them to get past passwords and gain use of the encryption program, it would be pretty easy for a hacker to unencrypt my files.”

When the final member of their group practice failed to show up with bad news, they grew concerned and went down the hall to her office. She was sitting at her desk with a big smile on her face. She said, “I can’t tell you how good I feel. I’ve been so concerned about keeping records on my computer that I finally decided it just wasn’t worth the worry. I printed out all my records, made extra copies that I put in my safe deposit box, and got rid of my computer. It was such a good move for me. I haven’t felt this good in days.”

It was only months later that she discovered, when reading the complaint filed against her, that she had done a poor job of trying to erase her hard drive before selling her computer, and that the person who had bought it had little trouble retrieving the supposedly erased files and reading all the details about her patients.

■ ■ ■

These scenarios remind us of the need for constant alertness, constant awareness of the ways that seemingly simple and abstract ethical principles in the ethics codes can find their way into our work, often in unexpected ways and at unexpected times. Anticipating potential problems like these begins with our understanding of the ethics codes themselves, the topic of the next chapter.

# Chapter 3

## ETHICS THEORIES AND CODES

The work we do as therapists is complex, difficult, and emotional. Yet, as a mental health profession we have often struggled to capture with words exactly what we do and even what we profess to do as therapists. The challenge of describing what we do has been debated from the start of our profession.

In 1949, the Boulder Conference tried to define psychotherapy in a way that it could be used to train clinical and counseling psychologists. Carl Rogers, then president of the American Psychological Association (APA) in 1947, appointed David Shakow to chair a committee on defining and teaching psychotherapy. The Shakow Report, adopted at the 1947 APA convention, resulted in the Boulder Conference two years later.

On August 28, 1949, the recorder for the Boulder Task Force for defining both psychotherapy and the criteria for adequate training provided the following summary: “We have left therapy as an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training” (Lehner, 1952, p. 547).

Since the Boulder Conference, other conferences and various groups have tried to define psychotherapy and the practice of psychology. For example, the *2002 Competencies Conference: Future Directions in Education and Credentialing in Professional Psychology* (Kaslow et al., 2004), identified competencies in professional psychology and discussed effective strategies for teaching and assessing these competencies (Kaslow, 2004; see also Belar, 2009; Fouad et al., 2009; Hatcher, 2015; Hatcher et al., 2013; Rodolfa et al., 2013). Similarly, the *European Association of Clinical Psychology and Psychological Treatment (EACLIPT) Task Force on Competences of*

*Clinical Psychologists* (2019) developed “a list of competences that should be acquired during regular studies of psychology with a clinical specialisation” (EACLIPT Task Force, 2019; see also Prado-Abril et al., 2019).

## **THEORIES OF ETHICS**

The difficulty reaching agreement on a definition of therapy is echoed in the difficulty agreeing on a basic theory of ethics. In this section we briefly review four theories of ethics to illustrate the vast diversity of ethics theories, which can be viewed as a strength. Put succinctly, having multiple lenses through which we can examine and question professional ethics codes and our own ethical decision-making is an advantage.

### **Utilitarianism**

Utilitarianism, developed by Epicurus, Jeremy Bentham, John Stuart Mill, Katarzyna de Lazari-Radek, and Peter Singer among others, holds that a guiding principle of ethics involves choosing whatever brings the most happiness and produces the least pain to the majority. According to Bentham (1780):

Nature has placed mankind [humankind] under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think .... The principle of utility recognizes this subjection, and assumes it for the foundation of that system, the object of which is to rear the fabric of felicity by the hands of reason and of law .... By the principle of utility is meant that principle which approves or disapproves of every action whatsoever ... according to the tendency it appears to have to augment or diminish ... happiness .... (p. 232–245).

Similarly, Mill (1863) wrote:

The creed which accepts as the foundation of morals, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure, and the absence of pain; by unhappiness, pain, and the privation of pleasure (p. 9).

This may seem like a fairly simple, almost easy, approach to ethics. However, de Lazari-Radek and Singer (2017) emphasize that figuring out what promotes the most happiness in every situation may present more of a challenge than following a set of rules.

The core precept of utilitarianism is that we should make the world the best place we can. That means that, as far as it is within our power, we should bring about a world in which every individual has the highest possible level of well-being. Although this may seem like mere common sense, it is often in opposition to traditional moralities. Most communities prescribe rules to be followed irrespective of whether the outcome will make the world better or worse. It is much easier to follow rules than to try to assess, each time one acts, which of the available options will have the best consequences (p. 711–717).

## **Kantian Ethics**

Utilitarianism focuses on results, consequences. Kantian ethics focuses on will and intention. Kant (1785/1998) wrote:



Nothing can possibly be conceived in the world, or even out of it, which can be called good, without qualification, except a good will. Intelligence, wit, judgement, and the other talents of the mind, however they may be named, or courage, resolution, perseverance, as qualities of temperament, are undoubtedly good and desirable in many respects; but these gifts of nature may also become extremely bad and mischievous if the will which is to make use of them, and which, therefore, constitutes what is called character, is not good .... A good will is good not because of what it performs or effects, not by its aptness for the attainment of some proposed end, but simply by virtue of the volition; that is, it is good in itself .... and considered by itself is to be esteemed much higher than all that can be brought about by it .... (p. 115–127).

Kant believed that we must always treat others as an end in themselves and never as simply a means to an end.

## **Feminist Ethics**

Brabeck and Ting (2000) open a discussion of feminist ethics by quoting the striking claim that feminism itself cannot exist separate from ethics: “In 1991, the political scientist Jean Bethke Elshtain wrote, ‘feminism without ethics is inconceivable’ ... According to Elshtain, all feminisms offer an ethical position that accompanies a political, activist agenda to achieve social justice and improve women’s lives” (Brabeck & Ting, 2000, p. 17). They then summarize five major themes running through feminist ethics, including:

1. The assumption that women and their experiences have moral significance.
2. The assertion that attentiveness and subjective knowledge can illuminate moral issues.
3. The claim that a feminist critique of male distortions must be accompanied by a critique of all discriminatory distortions.
4. The admonition that feminist ethics engage in analysis of the context and attend to the power dynamics of that context.
5. The injunction that feminist ethics require action directed at achieving social justice.

While ethics is an inextricable part of feminism, multiculturalism is an inextricable part of feminist ethics. Gartrell (2014) wrote that “any discussion of feminist ethics must incorporate diverse experiences due to race, ethnicity, class, and sexual orientation” (p. 137; see also Greene & Flasch, 2019; Hayden & Crockett, 2020; Powell et al., 2020).

Lerman (2014) discussed the work of the Feminist Therapy Institute in creating their own ethics code based on their conclusions about traditional ethics codes. Their view that most of the current ethics codes were not a good fit for feminist therapists included:

The recognition that most codes are reactive rather than proactive, that ethics is frequently viewed as a good-bad dichotomy rather than as a continuum of actions generated by the complex nature of human interactions, that ethics codes do not customarily teach how to make ethical decisions, that ethics codes have usually ignored issues especially pertinent to minorities and women and that complaint procedures most frequently focus on legally protecting the professional rather than displaying compassion toward the client.

## **American Indian Ethics**

In a commentary on the APA Ethics Code, The Society of Indian Psychologists (SIP; Garcia & Tehee, 2014) emphasized that:

Indigenous people have a holistic and inter-relational view of health. This view means that the Western-based concepts of body, emotions, mind, spirit, community, and land cannot be separated and that an individual cannot be separated from their relationships, including the generations before them and the generations to come. There are no distinctions between physical health, mental health, and spiritual health, which also means that my physical health, mental health, and wellbeing are related to yours (“we are all related”).

\* They set forth 12 essential concepts, including:

1. All things are sacred. Sacredness is not religiosity but a recognition that everything has an important role to play in the

universe. This idea of sacredness is respectful of reciprocal relationships, of family, of the community, of the environment, of the past, present, and of the future.

2. Life and development are understood in terms of cycles as opposed to a linear process.
3. Everything is connected. All beings (including the Earth, the environment, and events in the past, present, and future) respond to each other's actions. Every living system is a whole in itself, as well as part of a larger system. This explanation is an essential concept of full circle understanding.
4. Events in life can best be understood as lessons. There is an acknowledgment that this moment is part of the lesson of whom we were, are, and whom we are to become.
5. Respect and honoring are essential to true or long-lasting relationships. These need to be demonstrated in a way that recognizes the cultural context of the individual and the community.
6. Relevant healing places emphasis on the social, historical, and political contexts that have shaped Indigenous experiences, lives, and perceptions.
7. Relevant healing encourages balance and harmony within a person's life and in relationship to others; it encourages the growth of positive elements in a person's life and emphasizes the strengthening of resiliency.
8. Individuality is valued by how it improves the community. Collaboration is more highly valued than autonomy. Competition should enhance collaboration.
9. Sustainability is essential for all of us to survive and thrive. This generation is not the most important for all time. It is important to question: How can we live in a way that allows others to live? How can we live in a way that reflects respect to all those whom we impact?
10. Mystery, awe, wonder, intuition, and miracles occur naturally in everyday life. The fact that Western culture has not yet figured out how to measure them is irrelevant.

11. The best way to understand one's place and identity is in the context of past, present, and future within one's community. Any action may have broad consequences. It is important to consider how to act deliberately and thoughtfully.
12. Compartmentalism misses the beauty of the Whole. The Whole is often much more complex and functional than the sum of each individual part. Working with the Whole acknowledges the mystery of those things still unknown and that cannot be readily observed or measured.

## **CODES, ACCOUNTABILITY, AND CONFLICTS**

Difficulties defining psychotherapy with precision or agreeing on a basic philosophy of ethics do not free the profession from setting forth its own ethics. The hallmark of a profession is the recognition that the work its members carry out affects the lives of their clients, sometimes in direct, profound, and immediate ways. The powerful nature of this influence makes the customary rules of the marketplace—often resting on variations of the principle “Let the buyer beware”—inadequate.

Society asks and expects the profession to create and set forth a code of ethics that holds its members accountable. At its heart, this code calls for professionals to protect and promote the welfare of clients and avoid letting the professional's self-interests place the client at risk for harm.

Perhaps because society never completely trusts professions to enforce their own standards and perhaps because the professions have demonstrated that they, at least occasionally, are less than effective in governing their own behavior, society has established its own means for making sure that professions meet minimal standards in their work and that their clients are protected from incompetent, negligent, and dishonest practitioners. As a result, four major mechanisms have been developed to hold therapists and counselors accountable: (1) professional ethics committees; (2) state licensing boards; (3) civil (e.g., malpractice) courts; and (4) criminal courts. Each of these four mechanisms uses different standards, though they

may overlap. Behavior may be clearly unethical and yet not form the basis for criminal charges.

In some cases, therapists and counselors may feel that these different standards clash. They may, for example, feel that the law compels them to act in a way that violates the welfare of the client and the clinician's own sense of what is ethical. A national survey of psychologists found that a majority (57%) of the respondents had intentionally violated the law or a similar formal standard because, in their opinion, not to do so would have injured the client or violated some deeper value (Pope & Bajt, 1988). The actions reported by two or more respondents included refusing to report child abuse (21%), illegally divulging confidential information (21%), engaging in sex with a patient (9%), engaging in nonsexual dual relationships (6%), and refusing to make legally required warnings regarding dangerous patients (6%).

That almost 1 out of 10 of the respondents reported engaging in sex with a client using the rationale of patient welfare or deeper moral value highlights the risks, ambiguities, and difficulties of us evaluating the degree to which our own individual behavior is ethical.

Pope and Bajt (1988) reviewed the attempts of philosophers and the courts to judge those times when a person decides to go against the law (e.g., engage in civil disobedience). On one hand, for example, the US Supreme Court emphasized that in the United States, no one could be considered higher than the law: "In the fair administration of justice no man can be judge in his own case, however exalted his station, however righteous his motives, and irrespective of his race, color, politics, or religion" (*Walker v. City of Birmingham*, 1967, p. 1219–1220).

Conversely, courts endorsed Henry David Thoreau's (1849/1960) injunction that if a law "requires you to be the agent of injustice to another, then ... break the law" (p. 242). The California Supreme Court, for example, tacitly condoned violation of the law only when the principles of civil disobedience are followed

If we were to deny to every person who has engaged in ... nonviolent civil disobedience ... the right to enter a licensed profession, we would deprive the community of the services of many highly qualified persons of the highest moral courage (*Hallinan v. Committee of Bar Examiners of State Bar*, 1966, p. 239).

As Pope and Bajt note, civil disobedience (Gandhi, 1948; King, 1958, 1964; Plato, 1956a, 1956b; Thoreau, 1849/1960; Tolstoy, 1894/1951) is useful in many contexts for resolving this dilemma. The individual breaks a law considered to be unjust and harmful but does so openly, inviting the legal penalty both to demonstrate respect for the system of law and to call society's attention to the supposedly unjust law. King (1963) explained why civil disobedience can only be done openly, publicly, and never covertly:

I hope you are able to see the distinction I am trying to point out. In no sense do I advocate evading or defying the law, as would the rabid segregationist. That would lead to anarchy. One who breaks an unjust law must do so openly, lovingly, and with a willingness to accept the penalty. I submit that an individual who breaks a law that conscience tells him is unjust, and who willingly accepts the penalty of imprisonment in order to arouse the conscience of the community over its injustice, is in reality expressing the highest respect for law (p. 8–9).

However, counselors and therapists often find this avenue of openness unavailable because of confidentiality requirements. If we as individuals and a profession are to address the possible conflicts between the law and our ethical responsibilities, one of the initial steps is to engage in frequent, open, and honest discussion of the issue. The topic needs open and active discussion in graduate courses, internship programs, case conferences, professional conventions, and informal meetings with colleagues.

## **AMERICAN PSYCHOLOGICAL ASSOCIATION APPROACH TO AN ETHICS CODE**

Founded in 1892 and incorporated in 1925, the APA first formed the Committee on Scientific and Professional Ethics in 1938. As complaints were brought to its attention, this committee improvised solutions on a private, informal basis. There was no formal or explicit set of ethical standards, and the committee's work was done on the basis of consensus and persuasion.

A year later, the committee was charged with determining whether the organization needed a formal ethics code. In 1947, it decided that a formal code was necessary, stating "The present unwritten code is tenuous, elusive, and unsatisfactory" ("A Little Recent History," 1952, p. 425). The board of directors established the Committee on Ethical Standards for Psychology to determine what methods to use in drafting the code. Chaired by Edward Tolman, the committee members were John Flanagan, Edwin Ghiselli, Nicholas Hobbs, Helen Sargent, and Lloyd Yepsen (Hobbs, 1948).

Some members strongly opposed creating formal ethical standards, and many of their arguments appeared in the *American Psychologist*. Calvin Hall (1952), for example, wrote that any code, no matter how well formulated,

plays into the hands of crooks .... The crooked operator reads the code to see how much he can get away with, and since any code is bound to be filled with ambiguities and omissions, he can rationalize his unethical conduct by pointing to the code and saying, "See, it doesn't tell me I can't do this," or "I can interpret this to mean what I want it to mean" (p. 430).

Hall endorsed accountability, but he believed that it could be enforced without an elaborate code. He recommended that the application form for APA membership contain this statement:

As a psychologist, I agree to conduct myself professionally according to the common rules of decency, with the understanding that if a jury of my peers decides that I have violated these rules, I may be expelled from the association (p. 430-431).

Hall placed most of the responsibility on graduate schools. He recommended that "graduate departments of psychology, who have the power to decide who shall become psychologists, should exercise

this power in such a manner as to preclude the necessity for a code of ethics” (p. 431).

The APA Committee on Ethical Standards (APA Committee) determined that because empirical research was a primary method of psychology, the code itself should be based on such research and should draw on the experience of APA members. As Hobbs (1948, p. 84) wrote, the method would produce “a code of ethics truly indigenous to psychology, a code that could be lived.”

The board of directors accepted this recommendation, and a new committee was appointed to conduct the research and draft the code. Chaired by Nicholas Hobbs, the new committee members were Stuart Cook, Harold Edgerton, Leonard Ferguson, Morris Krugman, Helen Sargent, Donald Super, and Lloyd Yepsen (APA Committee, 1949).

In 1948, all 7,500 members of the APA were sent a letter asking each member “to share his [their] experiences in solving ethical problems by describing the specific circumstances in which someone made a decision that was ethically critical” (APA Committee, 1949, p. 17). The committee received reports of over 1,000 critical incidents. During the next years, the incidents, with their accompanying comments, were carefully analyzed, categorized, and developed into a draft code.

## **The First APA Code**

The emerging standards, along with the illustrative critical incidents, were published in the *American Psychologist* (APA Committee, 1951a, 1951b, 1951c). The standards were grouped into six major sections:

1. Ethical standards and public responsibility
2. Ethical standards in professional relationships
3. Ethical standards in client relationships
4. Ethical standards in research
5. Ethical standards in writing and publishing
6. Ethical standards in teaching



The draft sparked much discussion and several revisions. Finally, in 1952, it was formally adopted as the Ethical Standards of Psychologists, and it was published in 1953.

In 1954, information on the complaints that the committee had handled for the past 12 years, during most of which there had been no formal code of ethics, was published in the *American Psychologist* (“Cases and Inquiries,” 1954). During this period, the ethical principles most frequently violated were:

- Invalid presentation of professional qualifications (cited 44 times).
- Immature and inconsiderate professional relations (cited 23 times).
- Unprofessional advertisement or announcement (cited 22 times).
- Unwarranted claims for tests or service offered usually by mail (cited 22 times).
- Irresponsible public communication (cited 6 times).

## **The Empirical Approach to a Code Half a Century Later**

APA pioneers provided an array of reasons to use an empirical approach to create the code of ethics for psychologists. But a critical incident survey of APA members could also serve other purposes. For instance, the actuarial data of ethics committees, licensing boards, and civil and criminal courts can reveal trends in ethical or legal violations as established by review agencies, empirical critical incident studies. They can also reveal ethical dilemmas and concerns that are encountered in day-to-day practice by a diverse range of psychologists and not just those who are subject to formal complaint.

The APA critical incident study undertaken in the 1940s was replicated in the 1990s and published in the *American Psychologist* (Pope & Vetter, 1992). In this study, 1,319 randomly sampled APA members were asked to describe incidents that they found ethically challenging or troubling. [Table 3.1](#) describes 703 incidents in 23 categories provided by 679 psychologists.

**Table 3.1.** Ethical Problems Reported by a National Sample of APA Members.

<b>Category</b>	<b>Number</b>	<b>Percentage</b>
Confidentiality	128	18
Blurred, dual, or conflictual relationships	116	17
Payment sources, plans, settings, and methods	97	14
Academic settings, teaching dilemmas, and concerns about training	57	8
Forensic psychology	35	5
Research	29	4
Conduct of colleagues	29	4
Sexual issues	28	4
Assessment	25	4
Questionable or harmful interventions	20	3
Competence	20	3
Ethics and related codes and committees	17	2
School psychology	15	2
Publishing	14	2
Helping the financially stricken	13	2
Supervision	13	2
Advertising and (mis)representation	13	2
Industrial-organizational psychology	9	1
Medical issues	5	1
Termination	5	1
Ethnicity	4	1
Treatment records	4	1
Miscellaneous	7	1

Category	Number	Percentage
Source: Adapted with permission from “Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey,” by K. S. Pope and V. A. Vetter, 1992, American Psychologist, 47, 397–411, p. 399. Available at <a href="http://ks pope.com">http://ks pope.com</a> . Copyright 1992 by the American Psychological Association.		

Here is a sample of the ethical concerns that the psychologists described in this anonymous survey:

## Confidentiality

- “The executive director of the mental health clinic with which I’m employed used his position to obtain and review clinical patient files of clients who were members of his church. He was [clerical title] in a ... church and indicated his knowledge of this clinical (confidential) information would be of help to him in his role as [clerical title].”
- “Having a psychologist as a client who tells me she has committed an ethical violation and because of confidentiality I can’t report it.”
- “One of my clients claimed she was raped; the police did not believe her and refused to follow up (because of her mental history). Another of my clients described how he raped a woman (the same woman).”

## Blurred, Dual, or Conflictual Relationships

- “I live and maintain a ... private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that ‘conventional’ people can also feel confidence in. Clients often come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation,

healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations but doesn't give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!"

- "Six months ago, a patient I had been working with for three years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along and continue to do so. Currently they are living together, and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I'm currently trying to figure out if we can ever resume our friendship and under what conditions." [This latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients.]

## **Payment Sources, Plans, Settings, and Methods**

- "A 7 year-old boy was severely sexually abused and severely depressed. I evaluated the case and recommended six months' treatment. My recommendation was evaluated by a managed health care agency and approved for 10 sessions by a nonprofessional in spite of the fact that there is no known treatment program that can be performed in 10 sessions on a 7-year-old that has demonstrated efficacy."
- "Much of my practice is in a private hospital that is in general very good clinically. However, its profit motivation is so very intense that decisions are often made for \$ reasons that actively hurt the patients. When patients complain, this is often interpreted as being part of their psychopathology, thus re-enacting the dysfunctional families they came from. I don't do this myself and don't permit others to do so in my presence—I try to mitigate the problem—but I can't speak perfectly frankly to my

patients and I'm constantly colluding with something that feels marginally unethical."

- "A managed care company discontinued a benefit and told my patient to stop seeing me, then referred her to a therapist they had a lower fee contract with."

## **Academic Settings, Teaching Dilemmas, and Concerns About Training**

- "I employ over 600 psychologists. I am disturbed by the fact that those psychologists with marginal ethics and competence were so identified in graduate school and no one did anything about it."

## **Forensic Psychology**

- "A psychologist in my area is widely known to clients, psychologists, and the legal community to give whatever testimony is requested in court. He has a very commanding presence, and it works. He will say anything, adamantly, for pay. Clients/lawyers continue to use him because if the other side uses him, that side will probably win the case (because he's so persuasive, though lying)."
- "Another psychologist's report or testimony in a court case goes way beyond what psychology knows or his own data supports. How or whether I should respond."
- "I find it difficult to have to testify in court or by way of deposition and to provide sensitive information about a client. Although the client has given permission to provide this information, there are times when there is much discomfort in so doing."

## **Research**

- "I am co-investigator on a grant. While walking past the secretary's desk, I saw an interim report completed by the PI [principal investigator] to the funding source. The interim report claimed double the number of subjects who had actually entered the protocol."

- “I have consulted to research projects at a major university medical school where ‘random selection’ of subjects for drug studies was flagrantly disregarded. I resigned after the first phase.”
- “Deception that was not disclosed, use of a data videotape in a public presentation without the subject’s consent (the subject was in the audience), using a class homework assignment as an experimental manipulation without informing students.”

## **Conduct of Colleagues**

- “As a faculty member, it was difficult dealing with a colleague about whom I received numerous complaints from students.”
- “At what point does ‘direct knowledge’ of purportedly unethical practices become direct knowledge which I must report—is reporting through a client ‘direct’ knowledge?”
- “I referred a child to be hospitalized at a nearby facility. The mother wanted to use a particular psychiatrist .... When I called the psychiatrist to discuss the case, he advised me that, since he was the admitting professional, he’d assume full responsibility for the case .... He advised how he had a psychologist affiliated with his office whom he preferred to use.”
- “I see foster children who have little control over their lives and case workers who have little time/interest in case management. How can I maintain good professional relationships with those who don’t function up to their duties?”
- “A director of the mental health center where I worked was obviously emotionally disturbed, and it impacted on the whole center—quality of service to clients, staff morale, etc. He would not get professional help or staff development assistance.”
- “The toughest situations I and my colleague seem to keep running into (in our small town) are ones involving obvious (to us) ethical infractions by other psychologists or professionals in the area. On three or more occasions he and I have personally confronted and taken to local boards ... issues which others would rather avoid, deal with lightly, ignore, deny, etc., because

of peer pressure in a small community. This has had the combined effect of making me doubt my reality (or experience), making me wonder why I have such moral compunctions, making me feel isolated and untrusting of professional peers, etc.”

## **Sexual Issues**

- “A student after seeing a client for therapy for a semester terminated the therapy as was planned at the end of the semester, then began a sexual relationship with the client .... I think APA should take a stronger stance on this issue.”
- “I currently have in treatment a psychiatrist who is still in the midst of a six-year affair with a patient. He wishes to end the affair but is afraid to face the consequences.”
- “My psychological assistant was sexually exploited by her former supervisor and threatened her with not validating her hours for licensure if she didn’t service his needs.”

## **The Current APA Ethics Code**

The most recent version of the ethical principles (APA, 2017a), the *Ethical Principles of Psychologists and Code of Conduct With the 2010 Amendments*, is the 12th version. APA published versions of the code or amendments in these years: 1953, 1959, 1963, 1968, 1977, 1979, 1981, 1990, 1992, 2002, 2010, 2016. The current version consists of an introduction, a preamble, five general principles, and specific ethical standards. The preamble and general principles, which include beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people’s rights and dignity, are aspirational goals to guide psychologists toward the highest ideals of psychology. The specific ethical standards are enforceable rules of conduct.

The APA Ethics Code Task Force is in the process of revising the code, and has developed eight initial draft principles (APA Ethics Code Task Force, 2020, July 31). Additional principles seem to reflect attempts to incorporate evolving awareness of human rights and social responsibility. The aspirational guiding principles include

beneficence and nonmaleficence, human and civil rights, integrity, interrelatedness of people, systems and the environment, professionalism and responsibility, respect for the welfare of persons and peoples, scientific mindedness, and social justice.

## **CANADIAN PSYCHOLOGICAL ASSOCIATION'S APPROACH TO AN ETHICS CODE**

The CPA was organized in 1939, incorporated under Part II of the Canada Corporations Act in 1950, and received its Certificate of Continuance under Canada's Not-for-profit Corporations Act in 2013. In the mid-twentieth century, Canada was a geographically large country with relatively few psychologists. Because it would have been hard to bring these psychologists together to create an ethics code, "the Canadian Psychological Association ... decided to adopt the 1959 ... APA code for a three-year trial. This was followed by adoptions (with minor wording changes) of the 1963 and 1977 APA revised codes" (Sinclair & Pettifor, 2001, p. i).

Discontent with the APA code and the perception that it was not a good fit for Canadian psychologists led the CPA to create its own code. Prior to developing its own code, there was evidence of periodic discontent by CPA members with the APA code. For example, in a 1976 document titled "Alternative Strategies for Revising CPA's Code of Ethics," the statement was made that the 10 APA ethical principles were "clearly designed for the current American social and moral climate and geared to American traditions and law." However, it was not until the 1977 revision of the APA code that the discontent became serious.

Of particular concern was the fact that, in response to US court applications of antitrust law to professional activities, the APA had removed some of its restrictions on advertising. Many Canadian psychologists believed such application of antitrust laws ran the risk of changing the nature of the professional relationship from a primarily fiduciary contract to a commercial one (Sinclair et al., 1996, p. 7).

To create an ethics code, CPA began with a critical analysis of the international and interdisciplinary literature to determine the



primary purposes of codes of ethics and their perceived strengths and weaknesses. This was followed by sending out 37 ethical dilemmas to psychologists who were asked how they would act in these situations and, equally important, to describe their reasoning (Sinclair et al., 1987). The responses yielded four basic ethical principles (CPA, 1986):

1. Respect for the Dignity of Persons
2. Responsible Caring
3. Integrity in Relationships
4. Responsibility to Society

The original CPA ethics code opened with a Preamble, which included a model of ethical decision-making in which the four ethical principles are to be considered and balanced. The Preamble was followed by four sections. Each section included an ethical principle, identified the values that give definition to the ethical principle, and list the standards that illustrate the application of the principle to the activities of psychologists.

Although the code was revised in 1991 and 2000, its original structure and emphases on the four ethical principles and ethical decision-making remains (Sinclair, 1998, 2011).

The third revision of the Canadian Code of Ethics for Psychologists (CPA, 2017a) maintains the structure and emphases of previous editions of the Code, but with clarification, updates, and additions related primarily to the following themes:

1. The role of “the personal” (e.g., virtue, character, self-knowledge) in ethical decision-making
2. Additional examples on the application of the principles and values to the use of technologies
3. Additional attention to collaborative/interdisciplinary practice
4. More attention to the impact of diversity and globalization on both society and psychology

## **ADJUDICATION OF ETHICS COMPLAINTS FOR CPA AND APA**

In 1985, the CPA Board approved a framework for re-directing to a regulatory body any complaint against a CPA member who is registered with that regulatory body. Although CPA would review the outcome of adjudication of the complaint, this review is to determine whether the individual's CPA membership should be terminated or whether any conditions should be placed on the membership. The complaint is not re-adjudicated. This practice has remained in effect to the present. However, CPA does accept and adjudicate complaints about CPA members who are not registered, as well as complaints that regulatory bodies believe do not come under their jurisdiction.

In 2019, the APA issued the following statement:

## *Complaints Regarding APA Members*

APA has made changes to its adjudication program to better serve individuals who believe they have been harmed by a psychologist. Our focus now will be on providing information on other potential avenues for resolution that have a greater ability to take a desired action against an unethical psychologist. We only accept complaints against an APA member psychologist if there is no alternative forum to hear the complaint. If another forum takes an action against the member, the APA can review the matter at that time.

### *Is the Psychologist You Would Like to Complain About Licensed?*

If a state psychology licensing board has jurisdiction, we will not accept a complaint against them. (In the event that the licensing board makes a significant finding against the member psychologist, we will be informed and will review the behavior under a different process).

If you have a complaint against a psychologist, you should contact your local, state, provincial, or territorial psychology licensing board to determine if the psychologist is licensed and obtain information on filing a complaint with that licensing board. These state regulatory agencies control the ability of a psychologist to practice and are separate entities from APA. A complete list can be found at The Association of State and Provincial Psychology Boards.

There also may be other avenues for you to consider, even if the psychologist is not licensed. If you are a student wishing to complain about a faculty member, you should explore your school's grievance procedures. Similarly, faculty members can explore their institution's faculty grievance procedures. If the matter involves child custody issues, another avenue beyond filing with the licensing board would be to work with your lawyer to present your concerns to the judge.

### *Why Is This the Focus?*

As a membership organization, APA cannot revoke a psychologist's license or restrict a psychologist from practicing. We cannot obtain a monetary award for you or require that a

psychologist do something you request. As with most membership-based organizations, the most serious action that APA can take is expelling the member from the association with notifications. We also do not have powers of investigation that governmental bodies and others possess. In most situations, there is a licensing board or other body that can review your complaint in greater depth and provide you greater relief for unethical behavior.

If you would like to receive additional assistance in identifying another forum better suited to hear your complaint, please contact us. In the event you have a record of a significant finding against a member by a forum other than a licensing board, you may contact us to give us that information (APA, 2019a, para. 1–6).

As emphasized in [Chapter 1](#) and throughout this book, knowing the professional codes is important to ethical decision-making but it is not sufficient. Codes cannot stand alone and do the thinking and deciding for us, freeing us from our personal responsibility. The next few chapters focus on some other concepts—Dignity, Respect, Trust, Power, Caring, Culture, Social Justice, and Human Rights—that are key to ethical awareness, choice, and action.

## Notes

- \* From “Society of Indian Psychologists commentary on the American Psychological Association’s (APA) ethical principles of psychologists and code of conduct” by M. A. García & M. Tehee (Eds.), 2014. Society of Indian Psychologists (SIP). Retrieved from <http://www.aiansip.org>. Copyright 2014 by M. A. García. Adapted with permission.

# Chapter 4

## DIGNITY AND RESPECT

Recognizing the inherent value of our clients and treating them with deep regard for their humanity is fundamental to the work that we do as psychotherapists. It is striking and strange that key concepts like “dignity” and “respect” are absent from so many discussions of ethical decision-making. Perhaps it’s because we assume that we are drawn into this field because we see the inherent worthiness of people. Perhaps it’s because the terms seem vague, abstract, and hard to define. Perhaps it’s because we assume that dignity and respect look the same across cultures. Perhaps it’s because violations of dignity and respect rarely serve as the explicit focus of ethics complaints, licensing board actions, and malpractice suits. Perhaps it’s because we clinicians get caught up navigating the laws, rules, procedures, and paperwork related to carefully regulated areas like informed consent, insurance coverage, and confidentiality. And perhaps it’s because we are socialized in a society that works against treating each person with dignity and respect.

Despite such absence, associations like the Canadian Psychological Association (CPA) and the American Psychological Association (APA) emphasize dignity and respect as fundamental. CPA makes “Respect for the Dignity of Persons and Peoples” the first of four basic principles and the one generally given the most weight:

This principle, with its emphasis on inherent worth, non-discrimination, moral rights, distributive, social and natural justice, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger of bodily harm to someone (CPA, 2017b).

The Canadian Code goes beyond an emphasis on moral rights to embrace human rights, civil rights, and an array of other basic principles that recognize the importance of treating every person with dignity and respect

[Psychologists would] not promote, contribute to, nor engage in any activity that contravenes international humanitarian law (e.g., declarations, treaties, or conventions regarding: human rights; torture and other cruel, inhumane, or degrading treatment or punishment; economic, social and cultural rights; civil and political rights; rights of indigenous peoples; children's rights; weapons of mass destruction; destruction of the environment) (CPA, 2017a, IV.26).

For APA, “Respect for People’s Rights and Dignity” is one of the five basic principles, which are aspirational and inform the standards. APA’s ethics code states that:

Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices (APA, 2017a, Principle E).

An initial draft of the revision of the next APA Ethics Code includes eight draft aspirational principles, including “Respect for the Welfare of Persons and People.” A definition incorporates and expands the previous principle above:

**1. Respect for the Welfare of Persons and Peoples:**

Psychologists recognize that individuals live in complex ecological systems and identify as individuals as well as communities and groups. Respect for the worth of all Persons and Peoples is inherent and fundamental in this Ethics Code. They recognize and respect individual differences and roles, complex social identities, and derivations of culture as essential to the effectiveness of their work.

- Persons and Peoples have rights to privacy, confidentiality, and self-determination concerning their own welfare.
- Psychologists are proactive in understanding and addressing cultural and social diversity. They consider behavior to be influenced by diverse factors that are interdependent. Age, sexual orientation and gender diversity, race, ethnicity, culture, national origin, religion/spirituality, disability, language, immigration status, social class, economic status, education, and employment are notable of such influences.
- Psychologists recognize there are very specific ideologies, concepts, values, linguistics, and practices that are shared within communities. Psychologists acknowledge and endeavor to resolve such differences, especially when conflict occurs between culture and broader societal standards, except when to do so would violate human rights.
- Furthermore, psychologists consider that actions stemming from such differences have resulted in differential distributions of power and resources within the larger society. Therefore, psychologists strive to eliminate the effect of biases based on those factors on their work, and they do not knowingly participate in or condone activities of others based upon such biases.
- Indeed, psychologists promote resistance and resiliency against those societal behaviors, institutions, and cultural practices that create and maintain inequities in the acknowledgment and maintenance of the worth and dignity of individuals and groups. Psychologists promote the equal application of social justice and specific rights of individuals and communities.
- Psychologists recognize that due process based on specific circumstances is required for any abridgment of rights and that such limitations are temporary.
- Psychologists recognize that special safeguards may be necessary to protect the rights and welfare of persons whose vulnerabilities impair decision-making and that the level of

vulnerability and the need for such safeguards varies over time and context.

A new, additional related principle has been added as well, “Human and Civil Rights.” The description of the new proposed principle follows:

1. **Human and Civil Rights:** Psychologists recognize and understand human rights, which include civil, political, social, economic, and cultural rights. In so doing, they foster and promote the advancement of these inherent and fundamental rights, freedoms, and protections. Human and civil rights and liberties are fundamental to all work in which psychologists are involved and with all populations with whom psychologists engage.
  - Psychologists recognize that advancing human and civil rights improves the human condition and enhances the discipline of psychology.
  - Psychologists recognize the harmful consequences of human rights violations, including social injustices, and seek to mitigate the historical and contemporary impacts of such violations through their professional work.
  - Psychologists are alert to and make efforts to prevent, mitigate, and/or eradicate violations of human rights in their work and in other professional contexts.
  - Psychologists respect and promote equity, diversity, and inclusion for all humans through the application of psychological science.

Note:



While Human Rights serve as the basis of many goals and aims that relate to the way humans should interact, they must be deemed aspirational and dependent upon the good will of humankind. Because of human nature there will always be the risk for violations of Human Rights. Civil Rights and Civil Liberties however are defined and ensured by (codified within) the laws of a governing or constitutional body to its citizens. They are rights designed to ensure/guarantee fairness and protect/guard against discrimination or repression without regard to particular attributes of the citizenry. They are basic freedoms or rights enjoyed by all the citizens of a government by law without any further specificity. Although they may require legal or legislative intervention in order to be secured or obtained, civil rights and civil liberties are protected and cannot be taken away without due process.

Therefore, in the conduct of their activities, it is important that psychologists recognize both the basis for and the characteristics of human rights, civil rights, and civil liberties, their protections and their vulnerability for violation.

Clearly, the evolution of awareness in society of the importance of promoting dignity and respect, including human and civil rights, has influenced the profession of psychology.

When we strengthen, deepen, and broaden our ethical awareness, we hone our skills at catching ourselves whenever we fail to fully respect the dignity of our patients, perhaps by not paying careful attention to them. Most of us learn about this failure when we are on the receiving end. For instance, have you led a charmed life free of the sinking realization that the other person, who supposedly is there to help, was either not showing you the basic respect of paying attention or seemed intent on slowing or blocking you from getting the help you need? Consider the following scenarios to see if any feel familiar:

You walk into the store to buy a new coat and (good!) there are no other customers—just four sales clerks near the back of the store telling each other jokes—so you should be able to get in and out of there without standing in line to check out. You go over to the coats but no sales person comes over to ask if you need help. You pick out the coat you want, try it on to make sure it fits, and walk over to the register. The sales clerks seem blissfully unaware of your existence, even after you clear your throat a couple of times. Finally, you say, “I’d like to buy this coat. Would one of you be able to check me out?” The sales clerk nearest you turns around to see who’s talking, looking at you as if you’d burped loudly at a formal dinner. The clerk holds up an index finger, indicating that your opportunity to give the store your money will come soon and you should show some patience. Finally, one of the longest jokes in recorded history reaches its long-anticipated punch line, and not too long after, you have left the store with your new coat. Another “satisfied” customer.

• • •

You walk into another store and this time a manager, their face full of concern, practically runs over to you and asks, “Can I help you?” When you say, “just browsing,” they follow you around the store, a look of disdain on their face. It’s clear they didn’t think you belonged in the store, didn’t want you in the store, thought you came to shoplift, or cause some kind of trouble. Why would they think that? Did they think you couldn’t afford what the store had to sell? Was it your skin color? Your Rainbow Coalition pin? Your yarmulka? Your burqa? Your Black Lives Matter shirt? Why did the manager decide, just by looking, that you were not to be treated with dignity and respect?

• • •

You (calling a clinic near closing time to reach your child’s pediatrician before he leaves the country on a 2-week vacation): Hi, I’m hoping to reach Dr. Guzman before he heads for the airport. My child has come down with something and no one knows her like Dr. Guzman. Any chance he’s still there?

Receptionist: Oh, I just saw him packing his briefcase in his office. Let me run to catch him before he leaves, and I have to chase him

across the parking lot! [puts you on hold]

[You wait. And wait. You see in your mind's eye the old movie convention of clock hands whirring around to show the passage of time. Then you see calendar pages flying off the wall. And then finally!]

Receptionist: What were you waiting for? Oh, I'm sorry, he left a while ago.

■ ■ ■

You're on the phone with tech support: Hi, I'm hoping you can help me get my internet connection up and running again quickly because I've got a Zoom session scheduled for a patient in crisis in 5 minutes. Let me tell you what I've already tried so that we can save time not going through those initial steps. I've tried disconnecting everything from my router, unplugging it from the wall socket, waiting 10 seconds, then plugging it again, and reconnecting everything. Then I tried checking all the settings on my computer to make sure they were correct. Then I made sure my computer didn't have a virus that was messing things up. Anything else we could try?

Tech support: I am so sorry you are having trouble with our company's services, but I am sure that I will be able to help you reconnect to the internet. Let's start with this: First, please disconnect everything from your router, unplug it from the electrical socket, and wait about 10 seconds before we plug everything back in to see if that works.

■ ■ ■

Anyone who speaks to you using sentences that begin with: "No offense intended but ...", "I hope you won't take this the wrong way but ...", "With all due respect ...", or "You know I love you but ..."

For most of us, realizing when others cut us short on respect and dignity comes easier than realizing when we do it to others. What may be completely understandable under the circumstances and hardly worth noticing when we do it, becomes very clear when it is done to us—arrogance, intentional disrespect, veiled hostility, a

personality disorder, a lack of human decency, unforgivable, and part of a clear and consistent pattern of high crimes and misdemeanors.

This ethical responsibility often slips easily from our awareness. Even if treating others with full respect for their dignity is our goal and our custom, we are likely to face countless obstacles. Here are a few examples:

## **DIAGNOSTIC CATEGORIES**

We work in a world in which most of us must manage the DSM (Diagnostic and Statistical Manual of Mental Disorders), the ICD (International Classification of Diseases), insurance forms, and other forces that draw our attention to diagnostic categories and invite us to think of our patients in terms of which diagnostic labels apply. The powerful language of labels can distort or blot out completely the person behind the label. Some clinicians, particularly in inpatient and forensic settings, may stop using the patient's name entirely and use only the label, often in a way that seems to lack respect or dignity (e.g., "Time to see if that schizophrenic is ready for a home visit. You gotta be careful with schizos").

## **FINANCIAL CONCERNS**

We also work in a world where most of us must pay the bills and many of us face financial pressures. If we are in independent practice, the gain or loss of one patient, particularly one who promptly pays our full fee, can mark the difference in whether we're in the red or black that month and whether we can pay the office rent and our other bills on time. When each patient's fee can produce such an immediate powerful impact, it is hard not to have financial issues weighing on our mind as we decide whether this long-term patient is ready for termination or whether we're truly competent to work with that new patient we just screened.

## **FATIGUE**

When we're tired, it's hard to pay full attention to our patients, to take in what they may be telling us between the lines of what they

say, and to respond sensitively. When we're dragging through the day, it's easy to be short with others, to take things the wrong way, and to miss what's important.

## **PERSONAL PREDISPOSITIONS, BIASES, AND PREJUDICES**

We all have them—certain things we like and, of course, dislike about other people. Each of us could get a good start on our own private list of negative reactions by completing the following sentences, as many ways as possible, with complete honesty and without censoring ourselves:

- I can't stand it when someone ...
- I'd rather not be around someone who ...
- The worst kind of person is someone who ...
- The people who are responsible for more trouble in the world than anyone else are the ...
- The kind of person I'd hate to be seated next to on a long car trip is ...
- It's not politically correct to say it, but personally ...
- You may not like it but there's a good reason everyone says that all [members of some racial, ethnic, religious, or other group] are [name of some characteristic, usually negative]—It's true!

Our personal list may include negative emotional reactions evoked solely by someone's membership in certain social categories based on

- Religion
- Politics
- Race
- Skin color
- Ethnic group
- Caste

- Weight
- Intelligence
- Education
- Mental health status or disorder
- Country of origin or current citizenship
- Immigration status
- Income (or lack of it)
- Occupation
- Physical ability or disability
- Mental ability or disability
- Sexual orientation
- Gender identity
- Gender expression
- Speech (e.g., whether the person makes grammatical errors, uses slang unfamiliar to us, speaks our language with an accent)
- Age (e.g., someone who is very old)
- Dress
- Personal hygiene

These negative emotional reactions based solely on such categories have the potential to choke off our respect for the dignity of that person.

This chapter is a reminder that treating others with respect for their dignity is a basic ethic of our profession, one easily overlooked but facing countless challenges. None of us is perfect in this area. All of us will fall short more than once over the course of a career. It will suddenly strike us that we've been sitting with a patient for most of a therapy session and for most of that time our mind has been elsewhere; we'll breathe a deep sigh of relief as we terminate a patient, realizing that we never liked the person, never invested much in the therapy, and feel joy that we're rid of that person; a

patient will say something that somehow breaks through our shell and we'll discover that some time ago we'd lost our sense of shared humanity with someone who'd started to seem like a stranger. The Golden Rule is useful here, no less so for being a cliché: We must strive to treat our patients and others with the same respect for their dignity that we wish to receive from others.

# **Chapter 5**

## **TRUST, POWER, CARING, AND HEALING**

Psychotherapy is a remarkable venture. It harnesses three forces—trust, power, and caring—to help people heal. In our work, we face the ethical challenge of understanding, respecting, and handling carefully all three.

### **TRUST**

When we apply to states and provinces for professional status via licensure and certification, we accept the responsibility that comes with that status. Society expects us to be trustworthy, to avoid abusing the trust that people place in us. Society depends on us to fulfill that trust for the good of our clients as well as society. Ethical dilemmas can arise from the clash between the client's interests and society's interests, or between the client's interests and the therapist's interests. In return for assuming a role in which the safety, well-being, and ultimate good of clients is to be held as a sacred trust, we are entitled to the roles, privileges, and power that governments and society entrust to professionals.

This concept of trust is key to understanding the context in which clients enter into a working relationship with us. Clients expect or desperately hope that they can trust us. Many fear we might betray their trust. Some agonize over trust issues. Others find barriers to trust almost insurmountable. And others, like Black, Indigenous People of Color (BIPOC) clients come to therapy knowing that the profession we represent has violated their trust many times throughout history. Still others come to therapy unaware of how their problems trusting others have made it hard for them to love, work, and enjoy life.



Trust is at the core of therapy and clinicians put it to good use. In therapy we expect clients to walk into the consulting room of an absolute stranger and say things that they would say to no one else. We therapists may ask questions that would get us slapped, punched, or sued if we asked them outside of therapy. What patients tell us in confidence carries potential to be therapeutic or harmful depending how we use that information and/or, whether we violate the client's trust by breaking the sacredness of confidentiality. This potential to help or hurt has led virtually all states and provinces to recognize some form of professional confidentiality and therapist–patient privilege. Laws prevent therapists, with some specific exceptions, from talking to others about what clients share with them during therapy.

Therapy, like surgery, relies on trust. Surgery patients allow themselves to be physically opened up in the hope that their condition will improve. They trust or may reluctantly trust surgeons not to take advantage of their vulnerability to harm or exploit them. Therapy patients undergo a process of psychological opening up in the hope that their condition will improve. They trust us or want to trust us not to harm or exploit them. Freud (1952) noticed this similarity. He wrote that the newly developed “talking therapy” was “comparable to a surgical operation” (p. 467) and emphasized that “the transference especially ... is a dangerous instrument ... If a knife will not cut, neither will it serve a surgeon” (p. 471). Recognizing and respecting the potential harm that could result from psychotherapy was, according to Freud (1963), essential:

It is grossly to undervalue both the origins and the practical significance of the psychoneuroses to suppose that these disorders are to be removed by pottering about with a few harmless remedies ... Psychoanalysis ... is not afraid to handle the most dangerous forces in the mind and set them to work for the benefit of the patient.

As patients, only if we trust the therapist and their intentions are we likely to speak truthfully about—or even disclose at all—events and topics that make us feel fear, shame, guilt, anxiety, or all the other forms of discomfort and apprehension. Research by Farber et al. (2019) found that trust played a “role for clients concealing

depression symptoms; 42% of respondents saw it as a way to foster honesty. Increasing trust was also important to clients concealing mistreatment in relationships and even for those lying about self-harm” (p. 3203–3204).

Our ethical responsibility includes respecting our clients’ trust that we will do nothing that places them at risk for harm. When we betray the client’s trust, they may lose hope in the system and profession we represent and not just in us as individual providers. When we betray our clients’ trust, we can sometimes cause deep, pervasive, lasting damage. The poet Adrienne Rich wrote a vivid description of the effects of shattered trust:

When we discover that someone we trusted can be trusted no longer, it forces us to reexamine the universe, to question the whole instinct and concept of trust. For awhile, we are thrust back onto some bleak, jutting ledge, in a dark pierced by sheets of fire, swept by sheets of rain, in a world before kinship, or naming, or tenderness exist; we are brought close to formlessness (1979, p. 192).

Research by psychology professor Jennifer Freyd and her colleagues (e.g., Freyd, 1998; Freyd et al., 2005; Gobin & Freyd, 2014; Platt & Freyd, 2015; Smith, 2017) has explored and described how *betrayal trauma* can result when our trust is violated. Freyd emphasized:

Psychologically, betrayal is toxic to the mind and body. We know this from decades of research on betrayal trauma. People who are betrayed are likely to suffer mentally and physically. This is true whether the betrayer is a trusted person—like a psychotherapist or supervisor—or a trusted institution—like a clinic, hospital, or university. In the case of institutional betrayal, the harm can be particularly acute and even associated with increased thoughts of suicide (personal communication, August 7, 2020).

We all face the challenge of understanding what inspires and validates trust and what misreading, misunderstanding, or mishandling trust can mean for the client. For some of us, advanced degrees from prestigious universities, diplomate status and other certifications (often framed in the office), awards and honors (often framed even more prominently in the office), publications in

respected journals on topics related to what we want to work on in therapy, fame, and even an office in an impressive building may inspire our initial trust in a therapist. Surely someone with all those accomplishments must know what they're doing, some of us might think, rightly or wrongly. For others the realities of intergenerational trauma and institutionalized forms of oppression experienced many times at the hands of those deemed experts rightfully detract from our ability to trust us. Clients may think that we may not know what to do with them. Others know that we too have biases that affect how we treat them; yet, despite these valid concerns, clients hope to be proven wrong. They hope we can be of help so they can feel better.

But for some prospective patients, these markers may be warning signs and even barriers to trust (Alire, 2019; Okun et al., 2017; Sue et al., 2019). These markers may suggest to members of historically oppressed communities that the therapist is a member of the establishment that has inflicted prejudice, discrimination, hate, oppression, and injustice. For instance, some BIPOC may understandably assume that a White therapist holds the same racist views and practices that so many White people have held for generations, given the many ways in which systems and institutions provide unearned advantages (privilege) to White people. Some of these privileges include: hiring and promotion practices favoring Whites; juries less likely to convict White defendants or, after conviction, to impose the death penalty on White defendants for comparable crimes; and traffic stops being much less risky for White drivers than for Black drivers. BIPOC may believe that White therapists have accepted those views and enjoyed those benefits without acknowledging the taint, wrongness, and injustice of such unearned advantages, let alone working to dismantle racist or other oppressive systems.

A White therapist who reacts defensively to a client holding a version of such views—an extreme version might be “Why, there’s not a racist bone in my body. I have no racist views”—or tries to block or shunt side dealing with such trust issues honestly and openly, is on the wrong track. A well-intentioned response to an experience about discrimination, such as “Oh, I am sure they didn’t mean it that way” invalidates the reality and perceptions of the BIPOC client.

Many minorities may perceive that the therapist cannot be trusted unless otherwise demonstrated. Again, the role and reputation that the therapist has as being trustworthy evidenced in behavioral terms. More than anything, challenges to the therapist's trustworthiness will be a frequent theme blocking further exploration and movement until they are resolved to the satisfaction of the client (Sue et al., 2019, p. 109).

Similarly, not talking or addressing issues related to racism, anti-Semitism, sexism, heterosexism, cis-sexism, gendered-racism and other forms of oppression may signal to the client that the therapist does not see these social problems as significant, real, or important to how they impact clients who are members of various minoritized groups. This lack of attention to the lived experiences of BIPOC and those who experience other forms of oppression may further negatively impact a client's ability to trust that the therapist will hear, understand, and respect their experiences. The heart of trust is not about our telling clients to trust us, the credentials on our walls, or the buildings where we practice—the heart of trust is about who we are, about whether we treat our clients with dignity and respect, and about our actions and inactions.

## **POWER**

The trust that society and individual clients give to therapists is one source of power—for example, the power to respect and value that trust or to abuse and betray it. The role of therapist holds power ranging from superficial to profound, from fleeting to lasting. The following sections look at seven forms of power including: (1) power given by the state; (2) power to name and define; (3) power of testimony; (4) power of knowledge; (5) power of expectation; (6) power created by the therapist; and (7) the inherent power differential.

### **1. Power Conferred by the State**

State and provincial licensing confers power. Licensed professionals can do things that people without a license cannot. With patients' consent, surgeons can cut human beings wide open and remove

internal organs, anesthesiologists can drug clients until they are unconscious, and some therapists can recommend or administer mind or mood altering drugs to clients, all with the law's authorization. People will take off their clothes and willingly (well, somewhat willingly) submit to all sorts of indignities during a medical examination. They let physicians to do things to them that they would not dream of letting anyone else do.

Similarly, clients will open up and allow us as therapists to explore private aspects of their thoughts, feelings, and social lives, including their history, fantasies, hopes, and fears. Clients will tell us their most guarded secrets, material shared with literally no one else. We can ask questions off-limits to others. States and provinces recognize the importance of protecting clients against the misuse of this power to violate privacy. Except in certain instances, we are legally required to keep confidential what we have learned about clients through the professional relationship. Holding private information about our clients gives us power.

Through licensing, governments also invest us with the power of state-recognized authority to affect our clients' lives. We have the power to make decisions (subject to judicial review) about our clients' civil liberties. In some cases, we have the power to determine whether a person constitutes an immediate danger to the life of someone else and should be held against their will for observation or treatment. Alan Stone (1978), professor of law and psychiatry at Harvard University and a former president of the American Psychiatric Association, noted that in the 1950s the United States incarcerated more of its citizens against their will for mental health purposes than any other country, and that the abuse of this power later led to extensive reforms and formal safeguards.

The state has sometimes used the power of involuntary hospitalization to enforce social injustice. For example, in 1958, Black pastor and civil rights activist Clennon King "tried in vain to enrol at the all-White University of Mississippi" (Negro pastor pronounced sane, demands Mississippi apologize, 1958, p. 3). State troopers took him to a mental health institution where he was imprisoned against his will. Where he had been committed was kept secret from everyone for 48 hours. After being confined in the

mental health institution for 12 days, he was released when a panel of 17 doctors declared him sane. He regained his freedom only to face charges of disturbing the peace by trying to enrol in an all-White university and resisting arrest. He said, “My only fear of jail is what might happen to me in that jail—the authorities are the only ones who have threatened me” (Negro pastor pronounced sane, demands Mississippi apologize, 1958, p. 3).

In the 1940s and 1950s, the government of Quebec falsely diagnosed 20,000 Canadian children as mentally ill and imprisoned them in psychiatric institutions to enable the misappropriation of government funds (Boucher et al., 2008; Clément, 2016; Duplessis orphans seek proof of medical experiments, 2004). The children became known as the Duplissis Orphans, named after Mauric Duplessis, who governed as Premiere of Quebec for five non-consecutive terms between 1936 and 1959. These are only a few of the countless examples in which the field of mental health and therapists have acted in unjust ways causing harm to vulnerable populations, and engendering distrust in the mental health system.

## **2. Power to Name and Define**

We hold the power of naming and defining. To diagnose someone is to exercise power. In an ingenious study, Lam et al. (2016) showed clinicians a video of a woman describing how she experienced uncomplicated panic disorder. They then asked the clinicians to rate her problems and describe her prognosis. Research participants had been randomly assigned to three groups. One was given the woman’s personal details and background information, the second was also given a behavioral description consistent with borderline personality disorder, and the third was given one piece of additional information that included the label of a borderline personality diagnosis. The results showed the power of a diagnosis to affect perception and judgment. Their study found that “the BPD label was associated with more negative ratings of the woman’s problems and her prognosis than both information alone and a behavioural description of BPD ‘symptoms’” (p. 253).

In one of the most widely cited psychological research studies, “On Being Sane in Insane Places,” Rosenhan (1973) wrote, “Such labels,

conferred by mental health professionals, are as influential on the patient as they are on his relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophecy. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly” (p. 254).

Caplan’s description (1995) of psychiatrist Bruno Bettelheim’s analysis of student protesters reveals the potential power of diagnosis and other forms of clinical naming to affect how we view people:

In the turbulent 1960s, Bettelheim ... told the United States Congress of his findings: student anti-war protesters who charged the University of Chicago with complicity in the war machine had no serious political agenda; they were acting out an unresolved Oedipal conflict by attacking the university as a surrogate father (p. 277).

The power of naming and defining has been particularly harmful to BIPOC and members of other oppressed social groups. For instance, naming “homosexuality” as a mental illness, being gatekeepers of gender-affirming terms for transgender people, over-diagnosing Black children with externalizing behavioral disorders and Black adults with more severe forms of mental illness (e.g., bipolar disorder, schizophrenia) has contributed to the pathologizing of communities who are already suffering as a result of discrimination and hatred.

### **3. Power of Testimony**

We possess authority to change the course of lives when we testify as experts in the civil and criminal courts and through similar judicial or administrative proceedings. Our testimony can help determine whether someone convicted of murder is executed. It can be the deciding factor in whether a parent gains or loses custody of a child. It can shape a jury’s view of whether a defendant was capable of committing a crime, was likely to have committed it, was legally sane at the time the crime was committed or is likely to commit similar crimes in the future. It can lead a jury to believe that an uncle

sexually abused a young child or that the child either imagined the abuse or was coached as part of a custody dispute. It can help immigrant and asylum-seeking individuals regularize their status in the United States so they can live and work free from the fear of being separated from their families or deported to countries where their lives may be at risk. Our testimony can convince a jury that the plaintiff is an innocent victim of a needless trauma who is suffering severe and chronic harm or is a chronic liar, gold digger, or malingerer.

#### **4. Power of Knowledge**

Our role as therapist holds power beyond the power that a license creates. We hold power that comes from knowledge. We study human behavior, mental processes, and the intrapsychic and social factors that affect motivation, decision, and action. We learn methods to bring about change. Our research, writing, and our very words have the power of providing language and validation to experiences that have been marginalized, made invisible, silenced, and disregarded. Maintaining a constant, respectful awareness of the power flowing from knowledge and expertise is essential to avoid the subtle ways of manipulating and exploiting clients through our interaction with them or through our clinical documentation (treatment plans, progress notes, assessment report) and scholarship.

#### **5. Power of Expectation**

The process of psychotherapy itself creates and uses different forms of power. Most therapies recognize the force of the client's expectation that the therapist's interventions will be able to induce beneficial change. One aspect of this expectation is the placebo effect, a factor that must be considered when studying the efficacy and effectiveness of interventions. The client's investing the therapist with power to help bring about change can become a significant part of the change process itself. Conversely, the therapist's expectations, including optimism and belief in the client's capacity to change, are powerful as well. Miller et al. (1995) reviewed the research and noted that



As a factor in outcome, technique matters no more than the “placebo effect” ... The creation of such hope is greatly influenced by the therapist’s attitude toward the client during the opening moments of therapy. Pessimistic attitudes conveyed to the client ... are likely to minimize the effect of these factors. In contrast, an emphasis on possibilities and a belief that therapy can work will likely counteract demoralization, mobilize hope and advance improvement.

On the basis of their research, Connor and Callahan (2015) reported:

Psychotherapists were found to hold significantly higher expectations for client improvement than anticipated, based on existing literature, and these high expectations were found to be positively correlated with clinically significant change in clients. Moreover, psychotherapists’ expectations were found to explain 7.3% of the explainable variance in whether or not clients experienced clinically significant change during psychotherapy (p. 351).

Similarly, research conducted by Swift et al. (2018) found that student therapists’ expectations were a “significant unique predictor of change. These results suggest that therapists should be aware of their own expectations when working with clients in order to make sure that any negative beliefs do not impact the quality of care that they provide” (p. 84).

## **6. Therapist-Created Power**

In some approaches, the therapist works to create specific kinds of power. A family therapist may unbalance the equilibrium and disrupt alliances among family members. A behavior therapist may create a hospital unit or halfway/transitional house in which desirable behaviors bring a rewarding response from the staff (perhaps in the form of tokens that can be exchanged for goods or privileges); the power of the therapist and staff is used to control, or at least influence, the client’s behavior.

Psychologist Laura Brown (1994) describes another domain of the therapist’s power:

The therapist also has the power to engage in certain defining behaviors that are real and concrete. She sets the fee; decides the time, place, and circumstances of the meeting; and determines what she will share about herself and not disclose. Even when she allows some leeway in negotiating these and similar points, this allowance proceeds from the implicit understanding that it is within the therapist's power to give, and to take away, such compromises (p. 111).

## **7. Inherent Power Differential**

Power differential is inherent in psychotherapy. Although some approaches emphasize egalitarian ideals in which therapist and client are equal, such goals are viewed only within a narrowly limited context of the relationship. In truly equal relationships, in which there is no appreciable power differential, there is no designation of one member as “therapist” in relation to the other member, there is no fee charged by one member to the other for the relationship itself, there is no designation of the activity as “professional” (and falling within the scope of a professional liability policy), there is no license possessed by one member allowing initiation of a 72-hour hold on the other, and so on. A defining attribute of the professional is the recognition, understanding, and careful handling of the considerable power—and the personal responsibility for that power—inherent in the role. Regardless of how mutual, genuine, or egalitarian a therapist may choose to be, often utilizing humanistic, feminist (e.g., relational), multicultural orientations, some degree of power difference is unavoidable.

## **CARING AND HEALING**

Both the individual client and society recognize the diverse powers of the professional role and place their trust in us to use those powers to help—never to harm, oppress, or exploit. We must match with our caring the trust that society and the individual client invest in us. Only within a context of caring and healing—specifically, caring about the client's well-being, and working to not just help cope or adjust to intolerable circumstances but actually helping clients heal their pain—are our professional status and powers justified.

Historically, professional status was not created or defined by charging high fees, spending long years in training, or reaching a high level of skill. The professional's defining characteristic was an ethic of placing the client's well-being foremost and not allowing professional judgment or services to be drawn off course by one's own needs and wants. A major purpose of professional ethics codes is to help us use our knowledge, skills, status, and other forms of powers to help our clients and not to take advantage of, endanger, cheat, undermine, abuse, or otherwise mistreat or harm them. "Professional ethics protect the public against the abuses of professional power, specialized knowledge, and prominent positions. They place protecting the public interest above advancing the profession's self-interest" (Pope, 2019, p. 186). Professional ethics help keep us from being biased or blinded by our own self-interest so that we can no longer see clearly or care about our clients, their legitimate interests, and our responsibilities to them.

The touchstone for the approaches discussed in this book is caring for and about our clients. This book's concept of caring avoids passive, empty sentimentality. Caring includes responding to a client's legitimate needs and recognizing that the client must never be exploited. Caring also includes assuming personal responsibility for working to help and to avoid harming or endangering our clients. Caring involves learning to contextualize experiences and realities that may be completely different from our own so that we do not pathologize, misdiagnose, or misattribute behaviors that may be culturally congruent or blaming our clients for their reactions to oppression. Furthermore, caring means that we work on addressing our biases and prejudices as a way to ensure that we are able to treat all of our clients with the same level of respect and dignity. Caring is being a healing presence in the lives of those we serve.

Unfortunately, the concept of caring may not receive adequate attention in graduate training programs. As Seymour Sarason (1985) wrote:

On the surface, trainees accept the need for objectivity—it does have the ring of science, and its importance can be illustrated with examples of the baleful consequences of “emotional over-involvement”—but internally there is a struggle, as one of my students put it, “between what your heart says you should say and do and what theory and your supervisor say you should say and do.” Many trainees give up the struggle but there are some who continue to feel that in striving to maintain the stance of objectivity they are robbing themselves and their clients of something of therapeutic value. The trainee’s struggle, which supervisors gloss over as a normal developmental phase that trainees grow out of, points to an omission in psychological-psychiatric theories. Those theories never concern themselves with caring and compassion. What does it mean to be caring and compassionate? When do caring and compassion arise as feelings? What inhibits or facilitates their expression? Why do people differ so widely in having such feelings and the ways they express them? It is, of course, implicit in all of these theories that these feelings are crucial in human development, but the reader would be surprised how little attention is given to their phenomenology and consequences (positive and negative) (p. 168).

Sarason made some excellent recommendations for how to encourage and develop caring, compassion, and empathy in clinical training programs, and more recently other innovative approaches have begun to emerge (see, for example, Condon & Makransky, 2020; Fragkos & Crampton, 2020; Han & Kim, 2010).

We still have a long way to go in ensuring that clinical training programs, internships, professional organizations, clinics, hospitals, and other settings are doing all they can to support caring, compassion, and empathy among clinicians. Unfortunately, there is evidence that such qualities may actually decline in some settings (see, for example, Hegazi & Wilson, 2013; Hojat et al., 2004, 2009). In “Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents,” Neumann and her colleagues noted that the evidence of declines of empathy over the course of medical training, they describe:

Some of the studies included in our review reported significant increases in cynicism among medical students. Crandall et al. also found students' commitment to caring for medically underserved patients to be greater when they entered medical school than at graduation. This result was independent of gender and curriculum type (problem-based versus traditional; Neumann et al., 2011).

Caring about clients and what happens to them is at the heart of the formal rules and regulations that are society's attempt to hold us accountable, of our professional ethics codes, and of our personal ethical responsibilities to each patient.

# Chapter 6

## COMPETENCE, HUMILITY, AND THE HUMAN THERAPIST

When patients seek our services, they hope we know how to help them. Ethical practice hinges on competence, including our ability to use our skills effectively to help our clients heal and cope with the challenges they face. Society gives us the power and privileges to help our clients, while holding us accountable for competence through the courts and licensing boards.

Cynthia Belar (2009) discusses our ethical responsibility to train competent psychologists and to maintain our own competence as our “social contract.” She emphasizes that a central question for our training programs

is whether we are producing what we say we are producing—a psychologist competent for entry to practice. This question comes from prospective students, prospective employers, and the public. Indeed our social contract with the public as an independent profession requires that we self-regulate in these matters (p. S63).

The importance of that social contract was emphasized by The European Association of Clinical Psychology and Psychological Treatment (EACLIPT) Task Force on *Competences of Clinical Psychologists* (2019): “Politicians, societies, stakeholders, health care systems, patients, their relatives, their employers, and the general population need to know what they can expect from clinical psychologists” (p. 1).

Some patients may expect magic. For them, competence means that we can guarantee results, act flawlessly, and meet all needs. While this superhero, shero, or theyro role can be tempting, and some of us find it difficult to turn down potential worshippers, it is not realistic. We don’t have a magic wand that can disappear our clients’ distress,

pain, and difficulties. Unfortunately some therapists indulge their ego and take up residence in this delusional state.

This chapter is a reminder that as therapists, we are all human and imperfect. We all have weaknesses, blind spots, and biases, as well as strengths, abilities, and insights. Hence, it is important for us to keep a healthy dose of humility.

Failures of competence often spring from our human vulnerabilities. We face temptations, pressures, distractions, demands, and countless other forces. These forces can weaken our ability to know the limits of our competence and can sometimes block our ability to act effectively altogether. Consider, for example, the ways in which we have been socialized to respond to members of various groups. Unless challenged, this socialization affects our attitudes, beliefs, biases, and prejudices which may impact our competence to provide therapy or counseling to members of diverse groups. In addition, each of us has our own personal history, individual experiences, and an array of group-based reactions which can also impact our competence. See if the following self-assessment turns up any challenges to competence for you. Imagine you are in your office and a new patient walks in. Set aside for the moment whether you have training to work with a member of the group. Focus only on whether the patient's membership in a specific group evokes any reactions in you that might weaken your competence to welcome, become interested in, listen openly to, empathize with, and create a positive working relationship with them. Also, consider how you may respond if you are a member of a social group that has a history of being harmed by the new client's social group ([Chapters 7](#) and [23](#) provide more discussion). The array of patients you meet may include:

- A rich, young White man dressed in designer clothing and speaking in a condescending tone of voice.
- An extremely aggressive malpractice attorney who rarely loses a case, specializes in suing clinicians, and wins large judgments.
- A heavily tattooed teenager gang member with an accent, dressed in baggy pants that fall underneath his buttocks.

- A Black woman who is richer, more professionally successful, and personally happier than you ever hoped you could be and whose minor problem, which brought her to seek therapy, is one you've had for a long time and have been unable to overcome no matter what you tried.
- A member of US Immigration and Customs Enforcement (ICE) who comes dressed in uniform.
- A leader of the anti-choice movement who is deeply religious.
- A man who owns a string of "massage" parlors, which are occasionally raided by the police, resulting in the arrest of the young women who work there (but not their customers).
- A very successful political operative who opposes your most cherished values in the areas of social justice, human rights, and human well-being.
- Someone who uses racial slurs in therapy and sees that as freedom of speech and authenticity of self-expression.
- A gay-rights activist.
- A migrant worker who speaks English with an accent that is difficult for you to understand.
- A famous movie star.
- A man who has not bathed in a while because he lost his job and his water was cut off for nonpayment. He has an extremely strong body odor.
- A man under court order to seek therapy because he beats his wife.
- An animal-rights activist who breaks into research labs to free the animals.
- A physician whose specialty is performing abortions.
- A gun rights activist who carries a gun where open-carry laws allow but who also has a permit to carry a concealed weapon—He's coming to you because others keep telling him he has an anger problem and poor impulse control.



- A therapist who specializes in conversion or reparative therapy,
- An orthodox Jew
- A wealthy White woman who has had several plastic surgery procedures on her face who wants you to change all of your other appointments to accommodate her busy schedule.
- A Catholic priest.
- A devout Muslim woman who wears a full burka.
- A medical researcher whose experiments on dogs involve inducing disabling pathologies, painful surgeries, and death within a matter of months.
- Someone who believes in the intellectual, cultural, and moral superiority of their race.
- A Black academician who is seeking mental health services to address the racism he experiences at work.
- A gender expansive Filipino who uses they pronouns.

How did you do? Turn up any potential challenges to competence? Achieving awareness of these challenges puts us in a better position to handle them carefully, knowledgeably, and ethically, and to approach each situation with humility.

Our own values and experiences as members of different groups contribute to our biases, blind spots, and other limitations. Our ethical awareness depends on us becoming aware of these limitations. Despite our best efforts to spot problem areas, some of these challenges may stay hidden from our awareness for quite a while yet manifest themselves in our moment to moment interactions with our patients, supervisees, mentees, and colleagues. We may pride ourselves on our lack of biases toward certain groups and yet our behaviors may seem somehow “off.” Others may view what we say or do in regard to members of that group as avoidant, passive-aggressive, subtly hostile (words and behaviors sometimes termed “microaggressions”), or more openly biased—all of which may escape our attention. In addition, we may be well aware of the biases and prejudices that we have toward particular groups, but we may excuse them or view them as valid.

One tipoff that we may need to examine our competence to work with a particular group is if we talk about members of that group differently when they are present than when they are not within earshot. This difference in behavior, depending on whether members of a group are present, can be much more subtle than simply telling certain jokes, imitating accents, making generalizations about the group, and the like.

The theme of blind spots and biases affecting our competence on the individual level runs throughout this book and is a focus of [Chapters 7](#) and [23](#)—but a parallel theme is the way they affect the competence of organizations. For example, think of the different clinics, hospitals, and other agencies you’ve been to. Imagine the array of patients listed above each entering that agency, walking to the reception desk, and asking about getting help there. To what extent do you think each person would actually *feel* welcomed and get the help they need?

The opening chapters of this book rejected views of ethics as rigid rule following and presented an approach in which professional codes, administrative directives, legislative requirements, and other givens mark the start of a process of creative questioning and critical thinking. We search for the most ethical and positive way to respond to each unique patient with unique needs and resources in a unique context.

We carry on this creative questioning and critical thinking with a sense of humility as fallible human beings, vulnerable to fatigue, discouragement, frustration, anger, fear, and feeling overwhelmed. Our work depends on not just intellectual competence (knowing about and knowing how) but also what might be called *emotional competence for therapy* (Pope & Brown, 1996).

## **COMPETENCE AS AN ETHICAL AND LEGAL RESPONSIBILITY**

*Competence* is hard to define. Licensing boards and civil courts sometimes specify defining criteria for areas of practice. More often, they require only that in whatever area of therapy and counseling the clinician is practicing, they should possess demonstrable

competence. Demonstrable competence requires clinicians to produce evidence of their abilities. Usually this evidence comes from formal education, professional training, and supervised experience, followed by continuing education.

A competence requirement often appears in ethical, legal, and professional standards. Here are some examples:

- Section 1396, of California Title 16 states: “A psychologist shall not function outside his or her particular field or fields of competence as established by his or her education, training and experience.”
- Ethical Standard 2.01a of the APA’s “Ethical Principles of Psychologists and Code of Conduct” (2017a) states: “Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.”
- The Canadian Code of Ethics for Psychologists (CPA, 2017a) states that “psychologists recognize the need for competence and self-knowledge. They consider incompetent action to be unethical in itself, as it is unlikely to be of benefit and likely to be harmful. They engage only in those activities in which they have competence or for which they are receiving supervision, and they perform their activities as competently as possible” (p. 18).
- The American Counseling Association (2014) ACA Code of Ethics states: “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience” (p. 8). It also states that “multicultural counseling competency is required across all counseling specialties” and that “counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population” (p. 8).
- APA’s (2017a) *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* states: “It is important to note that, for the purposes of the *Multicultural Guidelines*,

cultural competence does not refer to a process that ends simply because the psychologist is deemed competent. Rather, cultural competence incorporates the role of cultural humility whereby cultural competence is considered a lifelong process of reflection and commitment” (Hook & Watkins, 2015; Waters & Asbill, 2013). This current iteration of the *Multicultural Guidelines* also recognizes the contributions of other culturally competent models of practice such as the American Counseling Association’s (ACA) *Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession* (Ratts et al., 2016); the American Psychiatric Association’s *Cultural Formulation Interview* (American Psychiatric Association, 2013); and the *Standards and Indicators for Cultural Competence in Social Work Practice* (National Association of Social Workers, 2015, pp. 8–9).

The ethical requirement of competence recognizes that the therapist’s power and influence (see [Chapter 5](#)) should not be handled in a careless, ignorant, and thoughtless manner. The complex, hard-to-define nature of therapy tends to cloud why this requirement makes sense. It becomes clearer by analogy to other fields. A physician who is an internist or general practitioner may do excellent work, but would any of us want that physician to perform coronary surgery or neurosurgery on us if they did not have adequate education, training, and supervised experience in these forms of surgery? A skilled professor of linguistics may have a solid grasp of a variety of Indo-European languages and dialects but be completely unable to translate a Swahili text.

## COMPETENCE AND CONFLICT

Pulled by patients holding exaggerated beliefs about our abilities and pushed by our own impulse to step in and help, our humility may fail us and we may resist admitting to ourselves and the client that we lack competence for a particular situation. We may need new clients to pay the bills and fear shutting off a valued referral source. Managed care may require us to take the patient. Nevertheless, extensive education, training, and supervised experience in working with adults does not qualify us to work with children; solid

competence in providing individual therapy does not qualify us to lead a therapy group; and expertise in working with people who are profoundly depressed does not qualify us to work with people who have developmental disabilities.

At times, complex situations require great care to determine how to respond to a client's needs while staying within our areas of competence. For example, a counselor may begin working with a client on issues related to depression, an area in which the counselor has had considerable education, training, and supervised experience. Much later the therapeutic journey leads into a problem area—bulimia—for which the counselor has little or no competence.

Alternatively, a client starts meeting with a counselor to deal with problems concentrating at work. Soon, the client says they suffer from agoraphobia. Can the counselor ethically assume that the course on anxieties and phobias that they took 10 years ago in graduate school makes them competent? The counselor must decide whether they have the time, energy, and interest in gaining competence through continuing education, study, or consultation to provide up-to-date treatment for agoraphobia or whether they need to refer the client or find some other way for the client to get competent help for agoraphobia.

Clinicians who work in isolated or small and rural communities often face this dilemma. They take workshops, consult long distance with experts, and come up with creative strategies to make sure that their clients receive competent care. Despite the clear ethical and legal mandates to practice only with competence, some of us suffer lapses. A national survey of psychologists, for example, found that almost one-fourth of the respondents indicated that they had practiced outside their area of competence either rarely or occasionally (Pope et al., 1987).

## **INTELLECTUAL COMPETENCE: KNOWING ABOUT AND KNOWING HOW**

Intellectual competence involves one's fund of knowledge or "knowing about." In our graduate training, internships, supervised experience, continuing education, and other contexts, we learn about

the research, theories, interventions, and other topics that we need to do our work. We learn to question the information and assess its validity and relevance for different situations and populations. We learn to create and test hypotheses about assessment and interventions. We find ways to keep up with the latest therapy research.

Part of intellectual competence is learning which clinical approaches, strategies, or techniques show evidence or promise of effectiveness and for whom do such techniques work. If clinical methods are to avoid charlatanism, hucksterism, and well-meaning ineffectiveness, they must work (at least some of the time). The practitioner's supposed competence means little if their methods lack competence. In his provocative article *The Scientific Basis of Psychotherapeutic Practice: A Question of Values and Ethics*, Jerry Singer (1980) emphasized the ethical responsibilities of clinicians keeping up with the emerging research basis of the methods they use.

Intellectual competence also means learning what approaches have been shown to be invalid or perhaps even harmful. George Stricker (1992) wrote:

Although it may not be unethical to practice in the absence of knowledge, it is unethical to practice in the face of knowledge. We all must labor with the absence of affirmative data, but there is no excuse for ignoring contradictory data (p. 544).

Intellectual competence is not frozen in time. David Barlow showed how quickly well-designed research can change our views of which interventions are effective, worthless, or even detrimental. "Stunning developments in health care have occurred during the last several years. Widely accepted health-care strategies have been brought into question by research evidence as not only lacking benefit but also, perhaps, as inducing harm" (Barlow, 2004, p. 869; see also Sue, 2015).

Intellectual competence also means admitting what we do not know. We may know about depression in adults but not depression in kids. We may be familiar with the culture of one Asian population but not others. We may understand the degree to which the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) can assess

malinger among criminal defendants but not whether it can identify leadership strengths among job candidates in the tech industry.

Intellectual competence also involves knowing how to do certain clinical tasks. We gain this kind of competence, the development of skills, through carefully supervised experience. We can't learn how to do therapy just by reading a book or sitting in a classroom; therapy is a set of skills that is learned through practice. The APA Ethics Code Standard 2.01c (APA, 2017a) encourages properly trained psychologists planning to provide services new to them to achieve competence in those new services through relevant education, training, supervised experience, consultation, or study. Both the APA Ethics Code (Standard 2.03) and the CPA's Ethics Code (Standards IV.3 and IV.4) recognize that knowledge becomes obsolete and that psychologists don't stop developing and maintaining competence when they become licensed.

## **EMOTIONAL COMPETENCE FOR THERAPY: KNOWING YOURSELF**

*Emotional competence for therapy*, as described by Pope and Brown (1996), reflects our awareness and respect for ourselves as unique, fallible human beings. It includes self-knowledge, self-acceptance, and self-monitoring. We must know our own emotional strengths and weaknesses, our needs and resources, our abilities and our limits for doing clinical work.

Therapy can stir strong emotions in both therapist and client. Some clinical work places great emotional demands on us. For example, working with people who survive torture can evoke intense reactions that can lead to secondary trauma, despair, helplessness, and burnout (Allden & Nancy Murakami, 2015; Comas-Diaz & Padilla, 1990; Long, 2020; Pope, 2012; Pope & Garcia-Peltoniemi, 1991). To the degree that we are unprepared for the emotional stressors and strains of therapy, our attempts to help may be futile and perhaps even harmful.

[Table 6.1](#) presents research findings about intense emotions experienced in therapy. The numbers indicate the percentage of

therapists in each study who reported at least one instance of each behavior. Readers who have had experience as therapists or patients may wish to compare their own experience to these findings.

**Table 6.1.** Percentages of Intense Emotions and Other Reactions in Therapy.

<b>Behaviors</b>	<b>Stud y 1<sup>a</sup></b>	<b>Stud y 2<sup>b</sup></b>	<b>Stud y 3<sup>c</sup></b>
Crying in the presence of a client	56.5		
Telling a client that you are angry at them	89.7		77.9
Raising your voice at a client because you are angry at them			57.2
Having fantasies that reflect your anger at a client			63.4
Feeling hatred toward a client			31.2
Telling your clients of your disappointment in them	51.9		
Feeling afraid that a client may commit suicide			97.2
Feeling afraid that a client may need clinical resources that are unavailable			86.0
Feeling afraid because a client's condition gets suddenly or seriously worse			90.9
Feeling afraid that your colleagues may be critical of your work with a client			88.1
Feeling afraid that a client may file a formal complaint against you			66.0
Using self-disclosure as a technique	93.3		
Lying on top of or underneath a client			0.4
Cradling or otherwise holding a client in your lap			8.8
Telling a sexual fantasy to a client			6.0
Engaging in sexual fantasy about a client	71.8	28.0 <sup>*</sup>	
Feeling sexually attracted to a client	89.5	87.0	87.3



<b>Behaviors</b>	<b>Study 1<sup>a</sup></b>	<b>Study 2<sup>b</sup></b>	<b>Study 3<sup>c</sup></b>
A client tells you that they are sexually attracted to you			73.3
Feeling sexually aroused while in the presence of a client			57.9
A client seems to become sexually aroused in your presence			48.4
A client seems to have an orgasm in your presence			3.2

<sup>a</sup>A national survey of 1,000 psychologists with a 46% return rate.

<sup>b</sup>A national survey of 585 Division 42 (Psychologists in Independent Practice) members.

<sup>c</sup>A national survey of 600 psychologists with a 48% return rate.

\*—This question asked about fantasizing about sex with a client while engaging in sex with somebody else.

*Source:* Study 1 from “Ethics of practice: The beliefs and behaviors of psychologists as therapists,” by K.S. Pope, B.G. Tabachnick, and P. Keith-Spiegel, 1987, *American Psychologists*, 42, pp. 993–1006. Study 2 from “Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system,” by K.S. Pope, P. Keith-Spiegel, and B.G. Tabachnick, 1986, *American Psychologist*, 41(2), pp. 147–158. Study 3 adapted from “Therapists’ anger, hate, fear, and sexual feelings: National survey of therapists’ responses, client characteristics, critical events, formal complaints, and training,” by K.S. Pope and G.B. Tabachnick, 1993, *Professional Psychology: Research and Practice*, 24, pp. 142–152. Copyright 1986, 1987, 1993 by the American Psychological Association.

Therapists, of course, bring something to the work they do. Each of us has a unique personal history. [Table 6.2](#) presents national survey results showing therapists’ self-reports of their experiences of various kinds of abuse during childhood, adolescence, and adulthood (Pope & Feldman-Summers, 1992). These results suggest that almost one-third of male therapists and over two-thirds of female therapists have experienced at least one of these forms of abuse over their lifetimes.

**Table 6.2.** Percentages of Male and Female Therapists Reporting Having Been Abused.

<b>Type of Abuse</b>	<b>Men</b>	<b>Women</b>
<i>Abuse during childhood or adolescence</i>		
Sexual abuse by relative	5.84	21.05
Sexual abuse by teacher	0.73	1.96
Sexual abuse by physician	0.0	1.96
Sexual abuse by therapist	0.0	0.0
Sexual abuse by nonrelative (other than those previously listed)	9.49	16.34
Nonsexual physical abuse	13.14	9.15
At least one of the above	26.28	39.22
<i>Abuse during adulthood</i>		
Sexual harassment	1.46	37.91
Attempted rape	0.73	13.07
Acquaintance rape	0.0	6.54
Stranger rape	0.73	1.31
Nonsexual physical abuse by a spouse or partner	6.57	12.42
Nonsexual physical abuse by an acquaintance	0.0	2.61
Nonsexual physical abuse by a stranger	4.38	7.19
Sexual involvement with a therapist	2.19	4.58
Sexual involvement with a physician	0.0	1.96
At least one of the above	13.87	56.86
<i>Abuse during childhood, adolescence, or adulthood</i>	32.85	69.93

Type of Abuse	Men	Women
<p><i>Source:</i> From “National survey of psychologists’ sexual and physical abuse history and their evaluation of training and competence in these areas,” By K.S. Pope and S. Feldman-Summers, 1992, <i>Professional Psychology: Research and Practice</i>, 23, pp. 353–361. Copyright 1992 by the American Psychological Association. Adapted with permission.</p>		

While these experiences may—or may not—affect emotional competence for any of us as individuals, it is important not to assume a one-size-fits-all theory about how forms of abuse (or any other experience) may affect an individual therapist. No research supports the notion that all those who have a history of abuse are more competent or less competent as therapists, or that those who have no history of abuse are more or less competent as therapists. Each instance must be evaluated on an individual basis, with the full range of available information and without stereotypes. What is key is for us to be aware of how such events affect us and what role, if any, they play in our emotional competence and our ability to respond effectively to clients.

Our work requires continuous awareness to prevent compromised performance, especially when we go through hard or challenging personal times. [Chapter 17](#) discusses common consequences when a therapist or counselor is distressed, drained, or demoralized. These common consequences include disrespecting clients, disrespecting work, making more mistakes, lacking energy, using work to block out unhappiness, pain, and discontent, and losing interest.

Emotional competence includes the process of constantly questioning ourselves. Consider the following: Do the demands of the work we do as therapists, or other factors, suggest that we need therapy in order to maintain or restore emotional competence? For many of us, creating self-care strategies that fit us as unique individuals and that sustain, replenish, and give meaning are an essential part of our work to maintain competence (see [Chapter 17](#)), particularly to maintain “emotional competence for therapy” (Pope & Brown, 1996; Pope, Sonne et al., 2006).

The psychology profession emphasizes the ethical aspects of self-care. General Principle A, Beneficence and Nonmaleficence, and Standard 2.06 of the APA Ethics Code (APA, 2017a) encourage psychologists to be aware of the possible effects of their own physical and mental health on their ability to help those with whom they work. The new proposed General Principle of Beneficence and Nonmaleficence also encourages psychologists to safeguard, protect, and contribute to the well-being, welfare, and rights of Persons and Peoples. Psychologists are also encouraged to maximize benefit and avoid or minimize harm in ways that respect the dignity of Persons and Peoples (APA Ethics Code Task Force, 2020, July 31).

The Canadian Code of Ethics for Psychologists, Standard II.11 (CPA, 2017a), states that psychologists “seek appropriate help and/or discontinue scientific or professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others.” Standard II.12 states that psychologists “engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others.”

The National Association of Social Workers (2017) and the American Counseling Association (2014) are among the other major mental health professions whose ethics codes highlight the role of self-care in supporting competence and preventing impairment.

[Table 6.3](#) presents the results of a national study of therapists as therapy patients (Pope & Tabachnick, 1994). Eighty-four percent of the therapists in this study reported that they had been in personal therapy. Only two respondents indicated that the therapy was not helpful, but 22% reported that their own therapy included what they believed to be harmful aspects (regardless of whether it also included positive aspects).

**[Table 6.3.](#)** Therapists’ Experiences as Therapy Patients.

Item	Never	Once	Rarely	Sometimes	Often
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<b>Item</b>	<b>Never</b>	<b>Once</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>
<i>In your own personal therapy, how often (if at all) did your therapist (N = 400):</i>					
Cradle or hold you in a nonsexual way	73.2	2.7	8.0	8.8	6.0
Touch you in a sexual way	93.7	2.5	1.8	0.3	1.0
Talk about sexual issues in a way that you believe to be inappropriate	91.2	2.7	3.2	0.5	1.3
Seem to be sexually attracted to you	84.5	6.2	3.5	3.0	1.5
Disclose that they were sexually attracted to you	92.2	3.7	1.0	1.3	0.8
Seem to be sexually aroused in your presence	91.2	3.7	2.2	0.8	1.3
Express anger at you	60.7	14.3	16.8	5.7	1.8
Express disappointment in you	67.0	11.3	14.8	4.7	1.3
Give you encouragement and support	2.5	0.8	6.2	21.8	67.5
Tell you the they cared about you	33.7	6.7	19.5	21.8	16.3
Make what you consider to be a clinical or therapeutic error	19.8	18.0	36.2	19.0	5.5
Pressure you to talk about something you didn't want to talk about	57.5	7.5	21.3	8.8	4.0
Use humor in an appropriate way	76.7	8.8	10.0	2.2	1.5
Use humor in an inappropriate way	5.2	2.5	12.5	35.0	43.5

<b>Item</b>	<b>Never</b>	<b>Once</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Often</b>
Act in a rude or insensitive manner toward you	68.7	13.0	12.0	4.0	1.5
Violate your rights to confidentiality	89.7	4.5	2.7	1.3	1.8
Violate your rights to informed consent	93.2	3.2	1.3	0.3	0.3
Use hospitalization as part of your treatment	96.2	1.8	0.5	0.5	1.0
<i>In your own personal therapy, how often (if at all) did you (N = 400):</i>					
Feel sexually attracted to your therapist	63.0	8.0	14.0	7.5	6.5
Tell your therapist that you were sexually attracted to them	81.5	6.2	5.5	3.0	2.7
Have sexual fantasies about your therapist	65.5	8.0	12.8	7.0	5.2
Feel angry at your therapist	13.3	9.5	32.7	28.5	15.0
Feel that your therapist did not care about you	49.5	13.0	19.0	12.3	5.5
Feel suicidal	70.0	8.5	9.5	8.3	3.0
Make a suicide attempt	95.5	2.5	1.0	0.0	0.0
Feel what you would characterize as clinical depression	38.5	15.8	16.0	16.5	12.5

*Note:* Rarely = two to four times; sometimes = five to ten times; often = over ten times.

*Source:* From “Therapists as patients: A national survey of psychologists’ experiences, problems, and beliefs” by K.S. Pope and B.G. Tabachnik, 1994, *Professional Psychology: Research and Practice*, 25, pp. 247–258. Copyright 1994 by the American Psychological Association. Reprinted with permission.

This research suggests that most therapists experience, at least once, deep distress. For example, 61% reported experiencing clinical depression, 29% reported suicidal feelings, and 3.5% reported attempting suicide. About 4% reported having been hospitalized. Readers may wish to consider their own experiences in the light of these findings.

*Emotional competence in therapy* is no less important than intellectual competence, and it is for that reason that we have included, beginning with [Chapter 15](#), clinical scenarios at the end of each chapter. These scenarios describe hypothetical situations that this book's readers might encounter. Each is followed by a handful of questions designed to provide practice in the processes of the critical thinking explored in detail in [Chapters 10–14](#). The first question in each sequence is a variant of “What do you feel?” Emotional competence leaves little room for denying, discounting, or distorting how we respond emotionally to the challenges of clinical work.

To the extent that these scenarios and questions form the basis of class or group discussion in graduate school courses, internships, in-service training, continuing education workshops, or other group settings, their value may be in direct proportion to the class's or group's ability to establish as safe an environment as possible in which participants are free to disclose responses that may be politically incorrect or “psychologically incorrect” (Pope, Sonne et al., 2006) or otherwise at odds with group norms or with what some might consider the “right” response. Only if participants are able to speak honestly with each other about responses that they might be reluctant to speak aloud in other settings and to discuss these responses with mutual respect, will the task of confronting these questions likely prove helpful in developing emotional competence (Pope, Sonne et al., 2006).

Learning to discuss these sensitive topics and our personal responses to them with others can help to strengthen our emotional competence and develop resources for maintaining competence throughout our careers (see Pope, Sonne et al., 2006, for a more thorough discussion of understanding taboos that hurt therapists and clients). Our colleagues also constitute an invaluable source of help to avoid or correct mistakes, identify stress or personal

dilemmas that threaten to overwhelm us, and provide fresh ideas, new perspectives, and second and third opinions. A national survey of psychologists, in fact, found that therapists rated informal networks of colleagues as the most effective resource for prompting effective, appropriate, and ethical practice (Pope et al., 1987). Informal networks were seen as more valuable in promoting ethical practice than laws, ethics committees, research, continuing education programs, or formal ethical principles. Our colleagues can help sustain us, replenish us, enrich our lives, and play an important role in our self-care ([Chapter 17](#)).



# Chapter 7

## CULTURE, CONTEXT, AND ETHICS IN PSYCHOTHERAPY AND COUNSELING

In the last few decades, the United States (US) and Canada have become more multiracial, multiethnic, and multilingual. As of 2019, 40% of the US population was Black Indigenous and People of Color (BIPOC) including: 18.5% Latinxs, 13.4% African American, 5.6% Asian American, and 1.3% American Indians (U.S. Bureau of the Census, 2019). Approximately 20% of the US population or 40 million are immigrants (Pew Research Center, 2020). In Canada, 22.3% of the total population in 2016 identified as People of Color and 21.9% of the population as immigrant. The largest ethnic minority community in Canada was composed of people of South Asian descent (5.6%), followed by Chinese (4.6%), First Nations (4.4%), and people who identify as Black (3.5%; Statistics Canada, 2016).

In the field of mental health, several foundational publications (see Comas-Díaz, 2012; Helms & Cook, 1999; Sue et al., 2019; Vasquez, 2007; White & Henderson, 2008) and professional guidelines (see American Psychological Association [APA], 2017b, 2019c; Canadian Psychological Association [CPA], 2017b) underscore the importance of ethnicity and culture in the therapeutic process. These important documents aim to assist therapists in providing culturally responsive services to individuals and communities. Culture, defined as the “complex constellation of [learned] mores, values, customs, traditions, and practices that guide and influence people’s cognitive, affective, and behavioral response to life circumstances” (Parham et al., 1999, p. 14) is an important aspect of the work that we do as therapists. Culture shapes how clients: (a) narrate and make sense of their presenting problems, describe the causes, signs, and symptoms

of their problems; (b) discuss what they believe heals or prevents the problems from getting worse; and (c) envision their relationship with healthcare providers including their therapist (Adames & Chavez-Dueñas, 2017; Gallardo et al., 2012; Kleinman et al., 1978; Vasquez, 2007). Culture always shapes how therapists view problems and issues, as well as what we consider to be healthy and unhealthy processes and functional and dysfunctional coping strategies (Vasquez & Johnson, in press). Culture is always in the therapeutic space, even when we fail to honor its presence and significance.

The concept of culture is sometimes misleadingly used interchangeably with race. However, the consensus among scientists, including social scientists, is that both concepts are distinct, albeit closely related (see Alvarez et al., 2016; Chavez-Dueñas et al., 2019; Helms & Cook, 1999). Specifically, race describes how individuals are grouped according to their shared phenotype (e.g., skin-color, eye-color, hair texture) and the social, educational, health, and political implications of this method of grouping (e.g., choosing to divide people up according to the color of their skin; see Bonilla-Silva, 2014; Carter & Pieterse, 2005; Chavez-Dueñas et al., 2014; Gannon, 2016; Helms & Cook, 1999; Ifekwunigwe et al., 2017; Jones, 1997). Said differently, race is a social construct and not a biological one. However, this social construct has real life and social consequences such as its impact on health and access to opportunities. The role of race, racism, colorism, and other forms of oppression (e.g., anti-Semitism, sexism, heterosexism) in ethics will be discussed in [Chapter 23](#). In this chapter we focus on culture and its implications for our work as therapists—we provide some steps to recognize and overcome barriers to ethical practice in the context of different cultures.

# CULTURE HAS ALWAYS BEEN A PART OF HEALING

Psychotherapy as a healing practice has existed for centuries in different cultures. However, the current practice of psychotherapy is often rooted in a Western philosophy with origins in Europe and the United States. Wampold (2001) explains that

The idea of sitting in a room with the healer, confiding in the healer, responding to questions, and following the implicit or explicit ritualistic expectations of the psychotherapeutic protocol, whether it is expressing one's feelings, monitoring one's thoughts, forming a contingency contract, or looking at the rapidly moving hands of the therapist, would be an absurdity in 99% of the societies past or present. On the other hand, participating in some healing practice is universal. As a healing practice, psychotherapy shares commonalities with medicine, but also with laying-on-of-hands, theriac, and shaman rituals. Psychotherapy is not universal; it has existed, in widely different forms, in some (but not all) Western cultures for about 100 years (p. 79).

There is also evidence that the Indigenous people of the Americas were using talk as a form of treatment for mental illness centuries before colonization. Padilla (1984) describes how the Aztecs had a well-developed system of public health that included healing services for mental health-related concerns where conversation was used to heal and care for others. He also wrote that

In essence it was believed that the *tonalpouhqui* [healer] had the knowledge and more authority to assist the patient by means of lengthy conversations designed to liberate them [from their ailments]. The personal characteristics and language of the *tonalpouhqui* were the major determinants for a successful outcome...The *tonalpouhqui* possessed concepts of ego formation and catharsis, as well as techniques of dream interpretation and psychotherapy similar to those developed later by Freud and Jung (p. 7).

These two passages exemplify the ways in which distinct cultural groups around the world used dialogue and other methods to

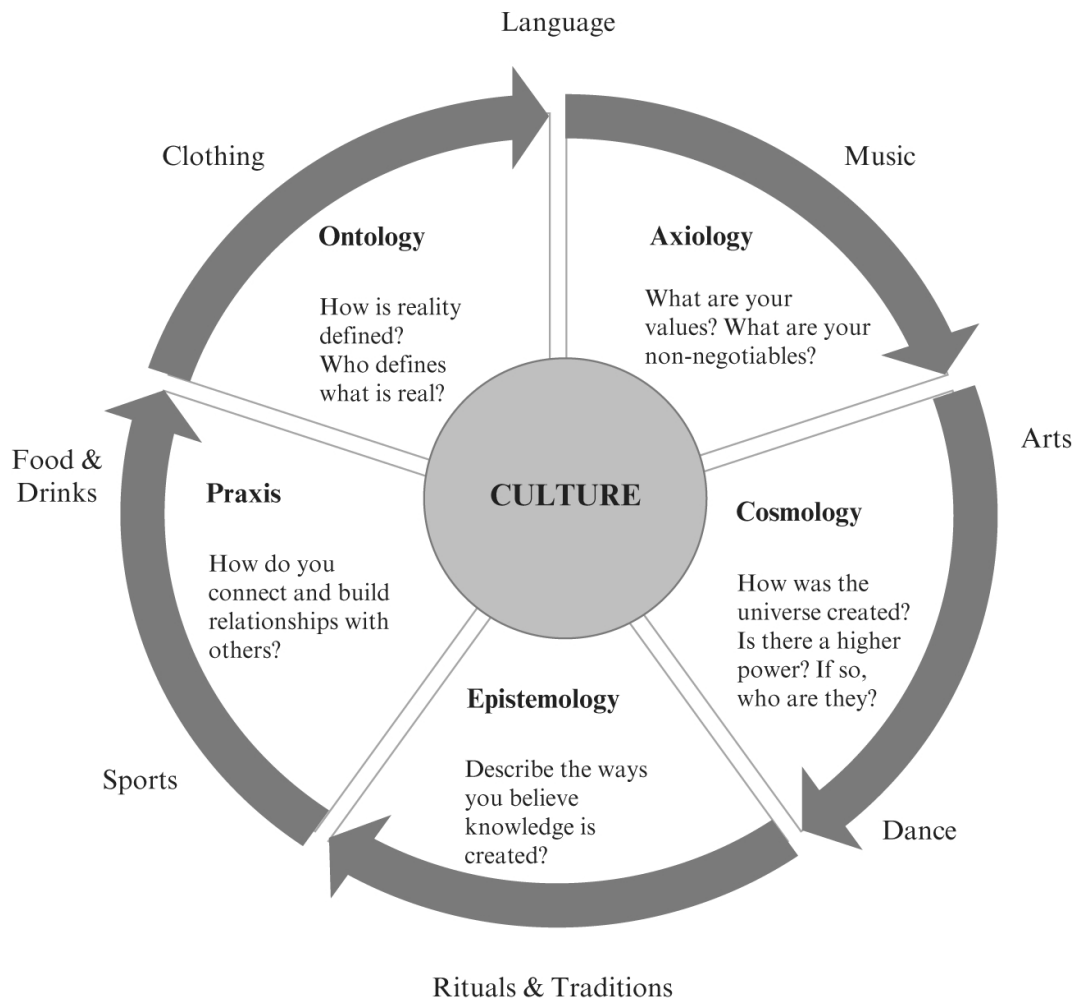
connect and build relationship to address the problems of living. However, the common ways in which psychotherapy is currently practiced are not culturally universal. Consider current counseling practices prevalent in the US, Canada, and many other Western countries: 45 to 55-minute sessions, once a week, often taking place in an office setting or using a Zoom connection, typically between two people. Few would argue that these practices are universal or free of cultural influence. To a great extent, they reflect Western standards and values. If so, how do we form healing relationships with clients of other cultures for whom such practices are a barrier? What do we need to learn about ourselves, the groups we belong to, and other cultures in order to communicate and work more effectively with those from other cultures? The following sections provide some ways to address these complex, arduous, but crucial questions.

## **CULTURAL COMPETENCE**

Psychotherapists are like all people. We too are shaped and influenced by many factors including our cultural heritage and our multiple social group memberships (e.g., race, ethnicity, gender, sexual orientation, religion, ability status). Subsequently, we navigate the world with a set of attitudes and ideologies that shape how we see ourselves and others. Indeed, you and I are “cultural beings,” all of our interactions are cross-cultural, and all of our life experiences are perceived and shaped from within our own cultural stance—the mantra and bedrock of cross-cultural and multicultural practice. As psychotherapists, our culture provides a rich context for becoming more aware of how our mores, values, customs, and traditions influence our own professional practice, ethical views, and reasoning. Ronald Francis (2009) wrote:

One of the singular merits of ethical considerations in a cross-cultural context is the way in which it forces us to confront our own values, to develop them, and to defend them. Cross-cultural comparisons afford a marvelous opportunity to examine the bases of our ethical codes in a manner which does not invite the heat more commonly attending intercultural value debates. Ethics is essentially about human values. Since not all values are shared, we are compelled to consider the issues we have in common; and those on which we divide. For instance, what may seem self-evident in one culture may be ethically repugnant to another. Ethics affords an opportunity to discuss and resolve these human values in a non-threatening frame of reference (pp. 182–193).

Ethical assessment and intervention also depend on our ability to understand culture beyond the surface level and popular culture (see [Chapter 20](#)). When considering the role of culture in psychotherapy, scholars have discussed and illustrated ways to examine and understand culture at the deep structural level, address how it impacts the psychotherapeutic process, and plan how to best integrate it into our practice (see Adames & Chavez-Dueñas, 2017; Gallardo et al., 2012; Parham et al., 1999; Vasquez, 2007). Five domains of culture at the deep structural level introduced and described by Ani (1994) include: *ontology* (nature of reality); *axiology* (value system); *cosmology* (relationship to the divine); *epistemology* (system of knowing and believing what is the truth); and *praxis* (systems of human interaction). Conversely, examples of surface level culture include food, holidays, celebrations, clothing, visual and performing arts, sports, dancing, language, and the like. The model in [Figure 7.1](#) illustrates culture at both the deep and surface levels, with questions to guide us to explore, unpack, and understand culture in nuanced ways.



**Figure 7.1.** The Deep and Surface Levels of Culture Model.

*Note:* The model aims to assist you in thinking about your own assumptions of how you conceptualize culture in your life and in your practice. The model includes two layers: (a) outer layer depicting culture at the surface; and (b) inner layer illustrating the five domains of deep culture. The domains of deep culture influence each other in non-linear but dynamic ways. Each domain includes question(s) for individuals and groups to consider when exploring their culture, which is continuously shaped by context and history. The model can also be used with clients to explicitly introduce and explore culture in therapy—therapists can compare their responses to that of their clients and assess areas where their deep cultures overlap and diverge, which can help inform the therapeutic process.

*Source:* Pope, Vasquez, Chavez-Dueñas, & Adames (2021).

Our professional responsibility to consider and integrate our clients' culture in therapy begins with a realistic appraisal of our own multicultural training and competence. When we hear of the word "competence" we often envision an individual who is a content expert, or perhaps someone who has reached the pinnacle in their career—we may also think of a group of people who know what to do in any situation—this is not competence. Instead, we invite you to think of competence as a process through which someone gains sufficient knowledge, judgment, and skills to carry out a task without doing harm. According to scholar practitioners, cultural competence involves three aspects: (a) developing awareness of one's own cultural values, traditions, and biases; (b) learning about the cultural values, traditions and worldviews of others; and (c) developing a set of culturally informed interpersonal skills (Mio et al., 2012; Sue et al., 2019; Vasquez, 2007). Accordingly, cultural competence is a continuing, life-long process of learning and relearning about ourselves and others as complex and layered cultural beings. In turn, this process strengthens our therapeutic alliance, increases the effectiveness of treatment, and deepens our ethical awareness and sense of personal ethical responsibility (see Arredondo et al., 1996; Casas et al., 2016; Fouad & Arredondo, 2007; Vasquez, 2007, 2009).

## **The Impact of Cultural Competence on Treatment**

Our cultural competence influences the experience that clients have in therapy. For instance, Smith and Trimble (2016) conducted a meta-analysis focused on therapists' cultural competence and its connection to clients' experiences in treatment. They concluded that

Diverse clients tend to see therapist multicultural competence as highly related to, yet distinct from, other positive counselor attributes. In addition, culturally diverse clients are moderately more likely to prematurely discontinue treatment when their therapists do not demonstrate multicultural competence. Client outcomes improve when their therapists are able to competently attend to and value the varying experiences of culturally diverse clients (p. 64).

More recent decades have seen an increase in scholarship describing and centering the role of culture in treatment outcomes. For

instance, the *evidence-based practice movement* in psychology frames evidence as the “best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, Presidential Task Force on Evidence-Based Practice, 2006, p. 273). This expansive description of evidence underscores the pivotal role of culture in psychotherapy outcomes. To illustrate, meta-analyses provide support for the effectiveness of culturally adapting psychotherapies for different groups (see Benish et al., 2011; Bernal & Domenech Rodríguez, 2012; Griner & Smith, 2006; Smith & Trimble, 2016; Zane et al., 2016).

The abundance of evidence supports the need to consider the client’s culture and our own cultural competence in the therapeutic process—not doing so can result in unintentional harm to clients (Vasquez, 2009, 2012; Sue, 2019). Thus, the inclusion of cultural factors in psychotherapy is not just a desirable practice, it is a fundamental ethical responsibility outlined in standards.

The CPA Code of Ethics Standard II.10 encourages psychologists to:

“evaluate how their own experiences, attitudes, culture, beliefs, values, individual differences, specific training, external pressures, personal needs, and historical, economic, and political context might influence their interactions with and perceptions of others, and integrate this awareness into their efforts to benefit and not harm others” (2017b, p. 19). Standard IV.15 requires that psychologists “acquire an adequate knowledge of the culture, social structure, history, customs, and laws or policies of organizations, communities, and peoples before beginning any major work there, obtaining guidance from appropriate members of the organization, community, or people as needed” (p. 33).

APA Ethics Code Standard 2.01b, Boundaries of Competence, states:



Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals, except as provided in Standard 2.02, Providing Services in Emergencies (2017b, p. 5).

Several psychological associations in the US have published documents that articulate and augment our ethical responsibilities within different cultural worldviews. Pope, Chavez-Dueñas, and Adames (in press) report that:

members representing the four Ethnic Minority Psychological Associations (EMPAs) in the United States including the *Asian American Psychological Association* (AAPA), *Association of Black Psychologists* (ABPsi), the *National Latinx Psychological Association* (NLPA), and the *Society of Indian Psychologists* (SIP) met with the APA Ethics Committee at the 2011 annual APA convention. During this meeting the EMPAs and APA agreed to review whether the ethics code addresses issues of culture adequately, appropriately, and knowledgeably. Specifically, the EMPAs shared their thoughts on how the ethical code both “assists or hinders their work as Psychologists of Color” with the goal of broadening knowledge on “how culture intersects with ethical dilemmas” (APA, 2012a, para. 15). Several EMPAs have developed and published their own set of ethical commentaries. (see SIP, 2014), guidelines (see NLPA, 2018), or standards (see ABPsi, n.d.).

## **CULTURAL COMPETENCE AND PROFESSIONAL GUIDELINES**

A focus on the role of culture in psychotherapy as practiced and regulated by state or provincial licensing laws is a relatively recent phenomenon. Historically, the field of mental health has been slow

at recognizing the significance of culture in psychological science, practice, and ethics (see Hall, 1997; Guthrie, 2004; Pickren & Burchett, 2014; Sue et al., 2019; Vasquez, 2007, 2012). The first mention of culture as a factor in therapy took place at the Vail Conference of 1973 (Korman, 1974). Sixteen years later, in 1990, the APA published its first guidelines that addressed culture titled, *The Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990). That same decade, the CPA approved and published their *Guidelines for Non-Discriminatory Practice*. Since then, both APA and CPA guidelines have been revised. In 2003, the new APA guidelines were published with a new title, *The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change* (see APA, 2003) and in 2017 they were revised once again (see APA, 2017b). The CPA guidelines were updated in 2001 and in 2017.

The 2017b version of the APA Multicultural Guidelines more broadly addresses the importance of attending to various identities and

encourage psychologists to consider how knowledge and understanding of identity develops from and is disseminated within professional psychological practice. Endemic to this understanding is an approach that incorporates developmental and contextual antecedents of identity and how they can be acknowledged, addressed and embraced to engender more effective models of professional engagement (APA, 2017b, p. 6).

Similarly, the 2017 CPA Guidelines for Non-Discriminatory Practice

promote non-discriminatory care in therapeutic work with clients, as well as to provide guidelines for evaluating the extent to which one's work falls within the parameters of non-discriminatory practice. As our society and culture become more diverse, and as we become more aware of specific diversities, it is important that psychologists gain an awareness of the need for non-discriminatory practice. As the need arises, guidelines can be developed for use of specific diversities (CPA, 2017b, p. 1).

The APA Guidelines on Race and Ethnicity in Psychology (2019c) more specifically focus on race and ethnicity

and describe how clinicians, educators and researchers can develop racial and ethnocultural responsiveness and discuss the importance of understanding bias and recognizing the influence of race and ethnicity in society (APA, 2019c).

These guidelines encourage psychologists to understand and consider the role of culture in practice, research, consultation, and education. Unfortunately, we have a long way to go in the field of mental health to move beyond just highly encouraging people to consider the role of culture in assessment and interventions to requiring the integration of culture as a standard in practice.

## **BUILDING CULTURAL COMPETENCE**

Building cultural competence in clinical practice often begins with effective training. Many programs in psychology and related fields historically have not provided adequate training on how to effectively integrate cultural knowledge into assessment and therapy. Adames et al. (2013) posit that

While psychology as a discipline maintains that diversity and multiculturalism training is important, some departments do not adequately address it as a central topic, emphasize its importance by making it a requisite, or provide a sound framework for effectively addressing diversity and multiculturalism (p. 3).

To what degree is culture and diversity respected, valued, welcomed, and its potential, approached in positive and creative ways? To what extent is it approached in ways that divide, isolate, set people against each other? For instance, several studies support how conversations about culture, ethnicity, and race provoke and exacerbate uncomfortable feelings including defensiveness, anxiety, anger, helplessness, blame, and invalidation (Bell, 2003; Helms & Cook, 1999; Sue et al., 2011; Utsey et al., 2005). Other scholars posit that when culture is addressed it is at the cost of Students of Color. Franklin (2009), for example, wrote:

Ethnic minority students often felt trapped between, if not victimized by, the roles of cultural educator and student. However, students as cultural brokers in class are often educators without a portfolio in the eyes of professors and fellow classmates. Challenging psychological information being presented that did not accurately represent our experiences could bring ... a label as an impudent student. Parenthetically, it was not uncommon to have our personal insights as members of the community also challenged or dismissed by professors or researchers who had no experience with our communities other than their readings in psychology. This was infuriating to many colleagues and students, given their lived experiences ... These in class and work experiences were frustrating, intimidating, humiliating, and discouraging to students and subsequently early career professionals in particular. This circumstance continues to contribute to the attrition of Students of Color in training programs and later becomes a deterrent to participation in organized psychology (p. 419; see also Kaduvettoor et al., 2009).

When we neglect how our own worldviews and cultural values influence the ways in which we navigate the world and interact with others—or when we fail to understand and appreciate the role of culture in our clients' lives and in the work that we do as therapists—we end up straying from the appropriate and helpful to the useless or even oppressive. We cannot operate from a one-size-fits-all approach to training and psychotherapy by applying frameworks and interventions grounded solely in the experiences of the dominant group (Burkard & Knox, 2004; Gómez, 2015; Sue, 2015). The road toward cultural competence, or the ability to develop interventions that are culturally responsive begins by looking inward toward the self and outward toward others.

## **Looking Inward**

We encounter people who practice different cultures and who differ from us in many ways as we go about our lives. We learn about cultural diversity in our studies, we work on developing ethical awareness in approaching it in our clinical work, but often we forget that we also carry our own private—and sometimes not so private—

views and feelings about specific cultures, races, religions, and so on. Most readers would have no trouble naming areas in the world in which people are fighting each other in part because of religion, culture, ethnicity, and similar factors. Most could name groups in their own countries that view members of another group with suspicion, unease, resentment, disdain, or hate.

It is impossible for us as therapists to be completely free of the prejudices that afflict the rest of humanity; after all, we are socialized in societies that have long histories of racism, colorism, nativism, ethnocentrism, and many other forms of othering (Chavez-Dueñas et al., 2019). Life is remarkable in so many ways, but not that one. For any of us, various cultural, racial, ethnic, political, religious, and other groups—or topics related to these groups—may evoke an intense emotional response. The response may be subtle or powerful. We may be ashamed of it or embrace it as important. We may be reluctant to mention it to certain people. We may view it as not politically correct or—a more forbidding barrier for many of us—as not *emotionally correct* (Pope, Sonne et al., 2006).

These psychological reactions may block or diminish our cultural competence to work with specific groups or certain topics. Thus, it is vital to assess not only our intellectual competence but also what Pope and Brown (1996) termed *emotional competence* for therapy. We invite each of us to take a moment now to ask ourselves the following set of questions:

- Do you have positive or negative feelings toward most or virtually all members of any particular social groups based on their cultural traditions, values, and practices? Does a person's skin color ever affect the way you view them or interact with them? How about a person's religion (e.g., Muslim, Southern Baptist, Catholic, Mexicayotl, Hasidic Judaism)? Social class (e.g., those people known as the super-rich; those people who are poor and homeless)?
- If so, how if at all do you think it affects your clinical work?
- Would you feel comfortable hiring, supervising, or accepting as a client, or working with a member of that group?

- Would you feel comfortable sharing these feelings with your graduate school faculty, internship supervisors, employer, or colleagues?
- Have you shared these feelings with your graduate school faculty, internship supervisors, employer, or colleagues?
- Would you be okay sharing your thoughts publicly? Posting them on public social media accounts?
- How well do you believe your graduate program, internship, and continuing education courses have dealt with these issues? What improvements could you suggest?
- How well do you believe the profession has dealt with these issues? What improvements could you suggest?
- Do you believe the profession is paying too much, too little, or just about the right amount of attention to these topics?
- How do your own cultural values inform and shape the way you interact with clients?
- How do they impact your assessment and diagnosis of clients of cultures different from your own?
- How do your cultural values impact or inform your interventions?
- Do you ever consider how the client's understanding, description, and expression of symptoms may impact treatment? If so, how do you integrate this information into your work?

Becoming aware of the ways we may fail to recognize and respect a group that is different from our own challenges all of us. It is easy to recognize in theory, the influence of our own culture and context, but it often escapes our notice in practice. A remarkable book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (Fadiman, 1997), illustrates the potential costs of overlooking the influence of culture and context on everyone involved. The book describes the efforts of a California hospital staff and a Laotian refugee family to help a Hmong child whose American doctors had diagnosed with epilepsy. Everyone involved had the best of intentions and worked hard to

help the girl, but a lack of awareness of cultural differences had tragic effects. The book quotes medical anthropologist Arthur Kleinman:

As powerful an influence as the culture of the Hmong patient and her family is on this case, the culture of biomedicine is equally powerful. If you can't see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else's culture? (p. 261).

## Looking Outward

Several models have been created to help us operate from a culturally responsive stance (see Adames & Chavez-Dueñas, 2017 *CREAR-CE Model*; Park-Taylor et al., 2009 *Multicultural Competency Training Model*). A well-established framework is White and Henderson's (2008) multicultural competency building model which includes an actionable plan to develop and maintain cultural competency throughout our mental health careers and beyond. This model is divided into four levels including: (1)

*conceptual/theoretical/intellectual* which underscores the importance of learning about our client's culture at the deep structural level obtained by reading textbooks and journals, attending lectures and courses, and watching movies/documentaries; (2) *engaging in challenging cross-cultural dialogues* that provide the opportunity for emotional growth through active participation in difficult dialogues around individual differences; (3) *behavioral engagement* which emphasizes the importance of immersing ourselves in the context/community of the people we serve; and (4) *building practical skills that enhance the therapeutic relationship* which focuses on developing healing approaches that are tailored to the unique and complex needs of our clients (also see Adames et al., 2016; Henderson et al., 2014).

According to White and Henderson, when we engage in activities at each of the four levels, we end up developing and deepening our cultural competency and improving the psychological services we provide.

## SCENARIOS FOR DISCUSSION

You share a suite of offices with several other therapists. The name of each therapist is on the door to that therapist's office. One morning you find that the door to one of the offices has been broken in and the office vandalized. The name on the door was Jewish. Swastikas along with epithets have been spray-painted on the walls, desk, floor, and bookshelves. You have no evidence but believe the vandal may have been one of your patients—someone who has expressed strong anti-Semitic views during therapy sessions, embraces the view that the Holocaust is fiction, and has described fantasies of vandalizing synagogues. But if you were to ask him during the next therapy session whether he had anything to do with vandalizing your colleague's office, he would deny it.

- How do you feel?
- What would you like to do?
- What do you think you would actually do?
- Would you mention your suspicion that your client may have vandalized your colleague's office to the colleague, the police, or anyone else? If so, how do you address issues of client privacy and confidentiality?
- Would you mention your suspicion to your client? If so, how?
- How, if at all, would you address your client's anti-Semitism in therapy?

...

You are a Latino psychotherapist who speaks Spanish only moderately well. Your policy is to try to refer all those who speak only Spanish to fluent Spanish speakers, but you will see Spanish speakers who also speak English if they wish. A South American client who speaks fluent English and Spanish sees you because you are the only Latino available on her HMO list. At the first session, she insists that you should be ashamed for not speaking better Spanish and that you therefore have no culture.



- How do you feel?
- What are your thoughts and feelings about this client?
- How would you respond to this client?
- Under what conditions would you continue to see or decline to see this client?

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You have been leading a therapy group at a large mental health facility. As one of the sessions begins, a group member interrupts you and says, “I want to ask you about something. Have you noticed how none of the doctors here are People of Color but almost all the cleaning crew are? Why do you work in a system like that? Don’t you think that has any effects on us patients?”

- How do you feel?
- What are the possible replies you consider?
- What do you think you would say?
- What effects, if any, might such a system have on clients?

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You work in a large office building. As your therapy client, a person of the Sikh faith, is getting ready to leave your office, the police show up at the door, handcuff him, and say they are taking him to the station for questioning. When they leave, the accountant across the hall comes over and says that someone saw your client in the lobby, thought he was acting suspiciously, and called the police to report someone who seemed up to no good.

- How do you feel?
- What do you consider doing?
- What would you like to do?
- What do you think you would do?
- How, if at all, might this affect the therapy?
- How, if at all, would you chart this?

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A married couple comes to you for counseling. Both believe that men are the natural leaders in a marriage and that a woman's rightful place is to be obedient to her husband. However, they often have what they describe as "slips," when he seems to look to her for guidance or when she finds it hard to accept his decisions. They are seeking marital counseling to help them eliminate these "slips."

- How do you feel?
- What are your thoughts and feelings about the wife?
- What are your thoughts and feelings about the husband?
- What are your thoughts and feelings about the marital relationship that they value and have chosen for themselves?
- How do you think you would respond?

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You work as a counselor in a high school where the majority students are African American and Latinx. You see clients in a small space right next to the principal's office. Most of your clients have been referred to you for "acting out" behaviors—they are often described by their White teachers as "lazy, unmotivated, and trouble-makers." In therapy your clients often talk about how the school is "not for them." They often discuss feeling not smart and that the teachers don't like them. During one of your sessions with a client who is crying while sharing a traumatic event, a teacher barges into your office and blurts out, "gosh, why do these kids have to be so loud, can you keep them quiet for once?"

- How do you feel?
- How would you respond to the teacher in that moment?
- What would you do when the teacher leaves?
- What would you say to your client?
- What would you do when your client leaves?
- What are your thoughts about what happened?

- What are your reactions to what happened?

• • •

You work with a geriatric population that is composed predominately of first-generation immigrants from Asia and Latin America. One of your Mexican clients, an 80 year-old woman comes to your session looking very serious. She begins her session by sharing that she wants to talk to you about what happened last night. She described having a conversation with her dead mother who came to give her a message. The message was that the mother was “not resting in peace” because your client was separated from her abusive husband. Your client states that her mother wants her to forgive her husband from whom she has been separated for over a decade. You have been working with this client for two years now to help her cope with the traumatic experience of living with a husband who abused her for decades.

- How do you feel?
- What are your thoughts? How are you making sense of the case?
- What would you say to your client?
- How would you chart this?
- What would you do?

You are a therapist at an agency with a policy that says that if a client misses two appointments without calling, the therapy automatically terminates. A client who is a single mother, uses public transportation, has no telephone, and is often distressed by a babysitter who does not show up, misses her appointment for the second time. Your supervisor insists that you terminate by letter, given the long waiting list of potential clients.

- What feelings do you experience?
- What are your assumptions about the client’s not showing up? In what way, if any, might her diagnosis be relevant?

- What do you think and feel about the relevance of the policy for clients such as this one?
- What are your options in responding to your supervisor? To the agency policy? To the client?
- Which options do you believe you would choose in deciding how to respond to your supervisor, the policy, and the client?

# **Chapter 8**

## **STEPS IN ETHICAL DECISION-MAKING**

Making sound ethical decisions depends on giving our full attention to all relevant facts in full and proper context, considering the relevant ethical values, and sorting carefully through the possible answers to the question: “What is the best thing to do here?”

Life is full of pressures and complexities, and it is so easy to miss a vital detail, key context, or creative solution. Competing values, cultural differences, conflicting regulations, scarce resources, misinformation, deadlines, physical and emotional exhaustion, fear of making a catastrophic mistake, and a stampede of other pressures and complications can make it hard to focus and think clearly, carefully, and creatively.

This chapter provides useful steps for understanding, thinking through, and responding effectively to ethical dilemmas, especially when we face conflicting values and ethical gray zones. The steps propose a process to help identify key facts and aspects of a situation, consider benefits and drawbacks of our options, and discover or create better approaches.

The Canadian Psychological Association (CPA) emphasized the importance of such steps by including 7 in its original ethics code in 1986 and increasing the number to 10 in subsequent editions in 1991, 2000, and 2017. The asterisks in the following list mark steps that are versions of those that appear in the CPA code.

Below we present 17 steps, while recognizing that not every step fits every situation, and some steps may need to be adapted.

### **STEP 1: STATE THE QUESTION, DILEMMA, OR CONCERN AS CLEARLY AS POSSIBLE**

Does your statement do the situation justice? Does it make it clear what the problem is and why it is a problem? Does it miss anything important to think through possible courses of action? Does any part of it get lost in the mists of vagueness, ambiguity, or professional jargon? Are some of the words misleading or not quite right? Is there anything questionable about the statement's scope, perspective, or assumptions? Does it speak clearly to any relevant cultural issues? Are there other valid ways to define the problem?

Tight schedules, urgent situations, and an eagerness to "solve the problem" can rush us past this step. Coming up with the best approach depends on our ability to clearly define and understand the ethical challenge we are facing. Formulating the problem is the first step in understanding and addressing it.

## **STEP 2: \*ANTICIPATE WHO WILL BE AFFECTED BY THE DECISION**

No one lives in a vacuum. How we respond may have profound consequences not only for the client, but also for the client's family, employer, coworkers, friends, and others. A client shows up for a session drunk. Whether the client drives home drunk and kills a pedestrian can depend on how we define our responsibility. A colleague begins to show signs of dementia of the Alzheimer's type. Our choices can affect the safety and well-being of the colleague, his family, and their patients. A therapy client tells us about embezzling pension funds. Confidentiality laws may direct us to tell no one else, and the client may refuse to discuss the issue. How we respond can determine whether hundreds of families retain the pensions they earned or are thrown into poverty and homelessness. An insurance claims manager refuses to authorize additional sessions for a client we believe is at risk for killing his partner and children and then committing suicide. Our supervisor may agree with the manager that no more sessions are needed. Whether the family lives, or dies may depend on what we do. Decisions can also affect other clients and as well as our community of mental health providers.

## **STEP 3: FIGURE OUT WHO, IF ANYONE, IS THE CLIENT**

One of the most important aspects of the decision-making is being clear about who is the client. Figuring out who is the *true* client is not always easy. Is there any ambiguity, confusion, or conflict about who the client is (if it is a situation that involves a psychotherapist-client relationship)? If one person is the client and someone else (e.g., a family member) pays our fee, do we feel any divided loyalty, any conflict that might shade our judgment? If we are treating someone under a court order, how do our responsibilities to both the individual and the court complicate our work and our answer to the question “Who is the client?” If we are hired by a large corporation to provide psychological services to the employees, is our client the corporation or each employee, and what do we do when the interests of the corporation and an employee collide?

## **STEP 4: ASSESS WHETHER OUR AREAS OF COMPETENCE—AND OF MISSING KNOWLEDGE, SKILLS, EXPERIENCE, OR EXPERTISE—FIT THE SITUATION**

In our practice we may encounter a wide range of clients facing an array of challenges. We may be familiar and experienced in helping clients address some of the difficulties they face, but there may be presenting problems that are new to us. As part of our ethical decision-making with each client we need to consider whether we are well prepared to handle this particular situation? What steps, if any, could we take to make ourselves more effective? In light of all relevant factors, is there anyone available to step in and do a better job? If so, what reasons weigh against referring the client? To what degree will consultation help? What role do these factors play in providing truly informed consent to a client?

## **STEP 5: REVIEW RELEVANT FORMAL ETHICS CODES AND STANDARDS**

The next step in the decision-making process focuses on understanding whether our professional ethic codes and standards speak directly or indirectly to the situation. Does this situation involve conflicts between different ethical standards or between the ethical standards and other (e.g., legal) requirements or values? In what ways, if any, do the ethics standards seem helpful, irrelevant, confusing, outdated, or misdirected when applied to this situation? Would it be helpful to talk with an ethicist, a member of a national, state, or provincial ethics committee, or a trusted colleague who has experience handling such conflicts?

## **STEP 6: REVIEW RELEVANT LEGAL STANDARDS**

Once we have determined whether the ethics codes and standards address the situation, we need to examine whether legislation and case law speak to this situation. Does a legal standard conflict with other standards, requirements, or values? Do the relevant laws support—or at least allow—the most ethical response to the situation, or do they seem to work against or even block the most ethical response? Would it be helpful to consult an attorney who has experience and expertise in these issues?

## **STEP 7: REVIEW THE RELEVANT RESEARCH AND THEORY**

Scholars and professionals in the field have written and researched many of the common dilemmas that we may experience in our professional roles. We can use this information to inform how best to proceed. We can begin by asking ourselves if we kept up with the emerging theory, research, and practice that might help us think through this situation. An occupational hazard of a field with such diverse approaches—cognitive, psychodynamic, pharmacological, behavioral, feminist, psychobiosocial, family, multicultural, and existential, to name but a few—is that we often lose touch with new ideas, findings, and approaches arising outside the walls of our own theoretical orientation.



## **STEP 8: \*CONSIDER WHETHER PERSONAL FEELINGS, BIASES, OR SELF-INTEREST MIGHT SHADE OUR ETHICAL JUDGMENT**

We often have personal reactions to situations we face. We may be impacted by preconceptions, biases, and self-interests. These factors need to be considered as we decide what to do. We can check-in with ourselves and consider if the dilemma makes us angry, sad, or afraid. Do we want to please someone? Do we desperately need to avoid conflict? Do we fear that choosing the most ethical path will get us into trouble, make someone mad at us, be second-guessed by colleagues, or be hard to square with the law or the ethics code? Do we personally have something to gain by taking a particular stance? Will doing the right thing cost us time, money, friends, referrals, prestige, a promotion, our job, our license, or sleepless nights? Being relentlessly honest with ourselves as we feel our way through as well as think our way through ethical challenges can help us avoid rationalizing our way off the path toward the most ethical response for this specific situation.

## **STEP 9: CONSIDER WHETHER SOCIAL, CULTURAL, RELIGIOUS, OR SIMILAR FACTORS AFFECT THE SITUATION AND THE SEARCH FOR THE BEST RESPONSE**

We are all racial and cultural beings embedded in a sociohistorical context. An act can take on sharply different meanings in different societies, cultures, or religions. What we do can be interpreted and experienced differently depending on factors like race, religion, politics, and socialization. The most ethical response in one context may violate sacred values in another society, culture, or spiritual tradition. We need to consider carefully what contexts—or conflicts between contexts—may have escaped our notice. Does our own social identity in relation to the client's social identity enter into the process? For instance, how does our own racialized, spiritual, and gendered development impact how we see and treat our clients? Could our own limited or biased view of other cultures, religions,

political beliefs, and so on throw off how we think through this ethical dilemma?

## **STEP 10: CONSIDER CONSULTATION**

Many of us have heard the common saying that two minds are better than one—in our professional lives, this saying materializes in the form of consultation. When thinking about an ethical dilemma we may consider if there is anyone who could help us think through the issues and possible responses? Who has expertise in the relevant areas? Is there someone who has faced a similar situation and handled it well—or who might tell us what does not work and what pitfalls to avoid? Is there a colleague whose perspective might be helpful? Is there someone whose judgment we trust? Especially when a situation is troubling to us and we are concerned by the lack of a clear ethical path, the old aphorism “Never worry alone” makes sense. Reach out to someone. When it’s hard to think of the right person to consult, it’s sometimes useful to ask ourselves: If what we decide to do were to end in disaster, is there some particular person we wish we had consulted?

## **STEP 11: \*DEVELOP ALTERNATIVE COURSES OF ACTION**

When we are working on a paper, we know that a first draft is just a first draft. We rewrite, edit, and develop several drafts until we believe that we have a draft that communicates our ideas clearly. This practice of writing and repeatedly revising parallels our ethical decision-making. Consider the many ways you can imagine of responding to this situation? What alternative approaches can you create? At first, we may come up with possibilities that seem “not bad” or “good enough.” The challenge—as it is with writing clearly—is not to quit too soon but to keep searching for our best possible response.

## **STEP 12: \*THINK THROUGH THE ALTERNATIVE COURSES OF ACTION**

Often there may be more than one possible way to deal with a particular situation. As we move through the process of making a decision, we can think about the impact that each action is likely to have—and what impact could each have under the best possible and worst possible outcome that you can imagine—for each person who will be affected by your decision, the immediate and longer-term consequences and implications for each individual, including yourself, and for any relevant organization, discipline, or society. We can also consider the following: What are the risks and benefits? Almost any significant action has unintended consequences: What could they be for each possible course of action? As with so many aspects of thinking through ethical dilemmas, one of the best strategies is to imagine that you decided upon the option, tried it out, and it ended in disaster: What flaws do you spot? What do you wish you would have considered before you acted on it? How could that option have been strengthened? Or should it have been discarded in favor of a better option?

## **STEP 13: TRY TO ADOPT THE PERSPECTIVE OF EACH PERSON WHO WILL BE AFFECTED**

Putting ourselves in the place of those affected by our decisions can change our understanding. What would each person consider the most ethical response? This approach can compensate for the distortion that often comes from seeing things only from our own perspective. One example is “correspondence bias” which refers to how we often explain our own behavior in specific situations as due to external factors while we tend to attribute the behavior of others to their dispositions.

Another example is what Meehl (1977) called a “double-standard of morals” (p. 232). This moral explains how we hold other people’s explanations to much higher scientific standards of logic, plausibility, persuasiveness, proof than we use for our own explanations.

## **STEP 14: \*DECIDE WHAT TO DO, REVIEW OR RECONSIDER IT, AND TAKE ACTION**

Once we decide on a course of action, we can—if time permits—rethink it. Sometimes simply deciding to choose one option and exclude all others makes us suddenly aware of flaws in that option that had gone unnoticed up to that point. Rethinking gives us one more chance to make sure we have come up with the best possible response to a challenging situation.

## **STEP 15: \*DOCUMENT THE PROCESS AND ASSESS THE RESULTS**

Documenting the process helps us remain clear about what went into our decision including the elements of the problem, the options and potential consequences, the guidance provided by others, and the perspective of the client along with the relevant rights, responsibilities, risks, and possible unintended consequences. Careful record keeping involves tracking not only what led up to our decision but also what happened afterward. What happened when we acted? Did we accomplish what we'd hoped and intended? Did unseen factors and unforeseen consequences spring up? Knowing what we know now, would we have taken the same path or tried a different response?

## **STEP 16: \*ASSUME PERSONAL RESPONSIBILITY FOR THE CONSEQUENCES**

If what we did seems clumsy, misguided, or downright wrong in hindsight, if it caused needless trouble, pain, loss, or problems, how do we respond to the fall-out of what we did or failed to do? Can we openly and honestly admit and own our mistakes and shortcomings and take clear steps both to set things right, if possible, and to avoid these missteps in the future?

## **STEP 17: \*CONSIDER IMPLICATIONS FOR PREPARATION, PLANNING, AND PREVENTION**

There are lessons that we may be able to learn from each decision we make or fail to make. Consider whether this situation, how we

responded, and the effects of our response suggest useful possibilities in the areas of preparation, planning, and prevention. What could we do to head off future problems or strengthen our responses? Would making changes in our policies, procedures, or practices help?

# Chapter 9

## MORAL DISTRESS AND MORAL COURAGE

When doing the right thing comes at a great and painful cost, trying to decide what to do can leave us feeling alone, afraid, or helpless. We might have thought through an ethical dilemma and found what we think is the right path. And yet ... that path may be closed off. Doing the right thing may be blocked by clinic policy, the hospital director, our employment contract, the insurance company, the budget, our packed schedule, or some other barrier.

We hate—or at least feel uncomfortable with—the idea that we are about to take part in something we know is wrong or to stand aside and let it happen. But to do what is right scares us into moral cowardice. We feel frozen, powerless. Doing what we think is the right thing might cost us our job, our license, our reputation, our income, our long-awaited promotion. We may also worry that doing the right thing might have no effect at all. No matter what we do, we cannot stop something that is deeply wrong—our only choice is to take part reluctantly, to witness the inevitable, or to dismiss what is wrong.

The aim of this chapter is to underscore a threat to ethical behavior that differs from so many others we face in our work. The vast majority of therapists devote themselves to the ethical path and always strive to do the right thing. But we're all human and we all fall short at least some of the time. Fatigue, carelessness, misperceptions and biases, misinformation, misjudgments, fallacies, pride, and impatience are only some of the hazards that trip up all of us at one time or another, causing us to overlook or turn away from the most ethical response. You can probably name several barriers off the top of your head without pausing too long to think about it.

All those hazards can cloud our ethical vision, causing us to miss what is most ethical. Additionally, barriers to an ethical path are external pressures convincing us that we cannot set foot on that path. Consider these examples:

As you show up at the clinic where you've provided outpatient therapy for the past 6 years, the chief administrative officer summons you to her office and informs you that due to a critical financial situation, the CEO and Board of Directors have ordered an emergency restructuring, effective immediately. You are to report now to their satellite clinic across town to assume new duties. Your current patients—some of whom are struggling with thoughts of suicide, some of whom you've diagnosed as suffering from Borderline Personality Disorder, and some of whom struggle with difficulties trusting a therapist—will be assigned to other therapists in the clinic. You will not be able to see them before they meet their new therapists, will no longer have access to their charts, and will no longer be allowed to communicate with them while they form working relationships with their new therapists.

You state as diplomatically as possible your concerns about not only ethical but also clinical problems with that approach. However, the CEO cuts you off, tells you that she and the CEO have thought through this plan carefully, that the extraordinary financial pressures call for extraordinary steps to keep the organization afloat, and that if you are unable to accept the new position as it has been laid out for you, she will unfortunately and with great sadness and reluctance, need to act immediately to hire your replacement. In an extremely tight job market, you need this job to support yourself and your family, especially since you're a single parent of three young children.

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You are the graduate student representative on the admissions committee for a small clinical psychology department. As the folders pass from person to person you notice an outstanding candidate who indicates, in her biographical sketch, that she is a devout Muslim. When the folder reaches the hyper-sensitive, opinionated, and dictatorial—and that's on his good days—chair of the clinical program, he tosses it aside and says, "Not while I'm chair of the program! I don't want to see our building blown up because someone didn't like her grades. So officially let's just write down in our notes that her academic interests are not a good



match for our program.” One of the other faculty members chuckles and nods their head; the others laugh.

You remain silent, burying your face in one of the other folders as if you’re reading intently, hoping nobody will pay any attention to you, realizing that to speak up within the context of this faculty would doom your prospects of success in the program. You also realize that if you let anyone outside the room know what just happened and there is any sort of complaint, publicity, or controversy, every faculty member will know that you were the leak.

Yet you believe what happened is deeply wrong—a violation of ethics, justice, fairness, legal standards, and the clinical program’s own stated policies. You believe the right thing to do is to speak up, and yet ... you hesitate, not wanting to face what will happen to you if you do. You ask yourself if you would find it easier to do the right thing if rather than Muslim applicants who were banned from the program in practice, though not in formal policies or public statements of inclusion and openness, it had been LGBT applicants, Black applicants, Latinx applicants, Jewish applicants, applicants who were older than 50, applicants with physical disabilities, applicants whose biographies described their activities in extreme right wing causes, or applicants whose biographies described their activities in extreme left wing causes.

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After taking out a large loan to support yourself during a 6-month dry spell of unemployment, you finally find a new job. You begin your first day of work at a well-regarded managed care system. Your supervisor explains that you’ll be doing intakes in the mental health department. You’ll be evaluating everyone showing up to ask for psychological services. Although the company touts their comprehensive mental health services, the supervisor tells you that you are to place everyone you can on a waiting list and warns you to be sure to write in your notes that your psychological evaluation showed no urgent needs for professional care. All others, he says, are to be assigned to one of the large therapy groups meeting every other week. For those, he directs you to write that your psychological evaluation showed that group

therapy was most appropriate for a patient with this particular set of clinical needs.

When you gently but firmly raise concerns about why this approach is wrong on so many levels, he says, “Look, just between you and me—and don’t quote me on this or I’ll deny I ever said it—I know what you’re talking about. But this company has been in business a long time and this is their business model. They quickly ‘reorganize’ any time they want to get rid of someone who is not on-board with the way they want things handled. If you fail even once to do what I’m telling you today, you’ll get a terrible weekly evaluation in your file, though it’ll list other reasons for why you’re not a good employee. If you fail to do it a second time, you’ll be gone within a few days.”

Those three examples represent what is often called “moral distress.” Andrew Jameton, professor in the University of Nebraska College of Public Health, pioneered the use of this term in his classic book on nursing ethics, defining it as what happens “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (1984, p. 6). He distinguished it from other ethical quandaries:

The experience of moral distress can be distinguished from the experience of moral dilemmas. In moral distress, a nurse knows the morally right course of action to take, but institutional structure and conflicts with other co-workers create obstacles. A nurse who fails to act in the face of obstacles also may have reactive distress in addition to the initial distress. Both kinds of distress pose dilemmas about individual and collective moral responsibility (1992, p. 542; see also Jameton, 1984).

Much of the early work on moral distress in clinical work focused on nursing. The American Association of Critical-Care Nurses’ Position Statement on Moral Distress (2012; see also Rittenmeyer & Huffman, 2009), summarized some major themes of over a quarter-century of research in this area and their implications:

Moral distress is a key issue affecting the workplace environment. Research demonstrates that moral distress is a significant cause of emotional suffering among nurses and contributes to loss of nurses from the workforce. Further, it threatens the quality of patient care. In recognition of these harmful effects, the provision of education and tools to address and manage moral distress in the work environment is imperative and will lead to essential improvements in patient care and outcomes.

When an organization inflicts moral distress on its members, the cause may go beyond the constraints created by one or a few individuals (e.g., a CEO, a supervisor). The organization's goals and values may create an ethical culture that clashes with some clinicians' deepest professional and personal values. Humphries and Woods (2015) wrote: "Moral distress is inevitable in an ethical climate where the organization's main priorities are perceived by nursing staff to be budget and patient throughput, rather than patient safety and care" (p. 265).

Although much of the research on moral distress has focused on organizational settings, therapists who are in independent practice may encounter it in other forms. Källemark et al. (2004) noted that "moral distress does not occur only as a consequence of institutional constraints ... [but also other constraints such as] legal regulations" (p. 1075).

The neutral clinical language that typically describes moral distress may drain it of impact as our eyes glide over it on the page. Fourie (2015), for example, writes that "moral distress should be understood as a specific psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both." Shay, in contrast, uses the term "moral injury" when describing what can happen to combat soldiers who are ordered to do something they believe is morally wrong. He writes of the "the soul wound inflicted by doing something that violates one's own ethics, ideals, or attachments" (Shay, 2012, p. 57; see also, 2002). Similarly, Litz et al. describe the pervasive harm we can suffer when we fail to do the right thing in important situations: "Potentially morally injurious events, such as perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral

beliefs and expectations may be deleterious in the long-term, emotionally, psychologically, behaviorally, spiritually, and socially (what we label as *moral injury*)” (2009, p. 695).

The deep moral distress that occurs when external forces push heavily against our will to do the right thing finds its way into many settings, including the healthcare worker frontline of the COVID-19 pandemic (Borges et al., 2020; Kröger); oncology and hematology (Lazzarin et al., 2012); pediatrics (Sauerland et al., 2015); intensive care (Hamric & Blackhall, 2007; Kok et al., 2020); health system management (Mitton et al., 2011); academic medicine (Ganske, 2010; Roberts, 2020); health promotion (Sunderland et al., 2014); community research: (Sunderland et al., 2010); and end-of-life care (Thurn & Anneser, 2020).

If you experience moral distress, you are far from alone, as the works cited in the prior paragraph suggest. “Moral distress is a common experience for clinicians, regardless of profession” (Whitehead et al., 2014, p. 117; see also Källemark et al., 2004). Studies chart its occurrence among psychologists (see, for example, Austin et al., 2005) and psychiatrists (see, for example, Austin et al., 2008).

Moral distress also occurs among clinical supervisees. Willingham (2017), for example, found that “supervisees who experienced moral distress often had poor supervision experiences. These included supervisors not listening to the supervisee’s way of conceptualizing, not discussing techniques or skills, discouraging the supervisee from giving clients optimal care, and encouraging supervisees to engage in behavior that they considered unethical” (p. 110; see also Nuttgens & Chang, 2013).

What factors are associated with moral distress among healthcare professionals? Lamiani, Borghi, and Argentero’s review of 17 studies found that “moral distress correlated with organizational environment (poor ethical climate and collaboration), professional attitudes (low work satisfaction and engagement), and psychological characteristics (low psychological empowerment and autonomy)” (2017, p. 51).

How do psychologists respond to moral distress? A study conducted by Austin et al. (2005) found six major ways of handling the experience:

1. remaining silent
2. taking a stand
3. acting in secret
4. sustaining the self by focusing on work with patients
5. reaching out to colleagues for support
6. leaving

The field can respond to moral distress by discussing it in graduate school, internships, continuing education courses, and professional conferences so that clinicians and clinicians in training learn about the phenomenon and its causes and can recognize it in themselves and others. We can develop supportive networks to help those experiencing moral distress to connect and consult with each other and seek additional sources of help. We can work to strengthen the ethics of organizations that inflict moral distress on their members, the focus of another chapter in this book.

But responding ethically and effectively to moral distress when we confront it in our individual lives will always require moral courage. We conclude this chapter with a striking profile in courage: A psychologist who took on a massive organization to protect his patients and was fired before ultimately prevailing. “The Psychologist as Whistle Blower: A Case Study” tells in careful and vivid detail the story of an individual’s long and hard struggle to do the right thing, and the roles that the Veterans Administration, professional associations, the Civil Service Commission, and others played. We appreciate the American Psychological Association, which holds the copyright to this article, for generously granting us permission to reprint much of the article here.

The following excerpts, as they appeared over almost four decades ago, show us all what true courage can look like—and does—in the face of moral distress and overwhelming odds.

## **\*THE PSYCHOLOGIST AS WHISTLE BLOWER: A CASE STUDY**

Although whistle blowing is an issue of wide social relevance, it has particular significance for psychologists, and other professionals, who are salaried employees. Because they occupy two statuses simultaneously, professional and bureaucrat, the opportunities for conflict between the demands of their conscience and those of their organization are greatly increased in comparison to other employees. The separation between employer and client may force a choice between loyalty to the organization and loyalty to professional ethics, a situation not faced by the traditional self-employed professional. The resolution of such conflicts may require the psychologist either to acquiesce in professionally unconscionable practices or to expose the practices publicly. Thus, whistle blowing, for psychologists, may not only be a matter of personal conscience but a professional responsibility as well ....

It is also a matter of high personal risk. Intense economic and organizational pressures appear to have successfully stifled much internal dissent and to have maintained whistle blowing as a rare and personally costly response (Committee on Scientific Freedom and Responsibility, 1975; Nader, Petkas, & Blackwell, 1972; Peters & Branch, 1972). As a result, both the public and the profession stand to suffer. Clients and the community at large may be subjected to unnecessary danger or expense while psychology's ability to function as an independent, autonomous profession is attenuated.

Psychologists, therefore, have an important stake in what happens to their colleagues who become whistle blowers. Accordingly, it is important to document publicly cases, such as the one described below, in which psychologists allege that they have received punitive treatment for following the dictates of their professional conscience. Documentation of such cases may contribute to a climate of opinion and an awareness of needed social or professional changes that will reduce the likelihood that institutional power will be abused in the future.

## **BACKGROUND**

In February 1971, a serious earthquake struck Southern California. Although there were relatively few deaths, there was extensive property damage. Especially hard hit were several Veterans

Administration (VA) hospitals. As a result of the damage, the VA launched a general survey of structural stability of other hospitals in the area. Among those surveyed were Brentwood Hospital, Wadsworth Hospital, and the Extended Care Hospital, three administratively separate facilities sharing the grounds of the National Military Home in west Los Angeles adjacent to the campus of the University of California (UCLA). Although these three hospitals had come through the earthquake unscathed, the VA announced nearly 1 year later that engineering tests indicated that a number of buildings might be unsafe in the event of another major earthquake. Therefore, these buildings were ordered closed.

Building 156, which housed the Adult Restoration Program at the Extended Care Hospital, was one of the buildings ordered closed. Donald Spiegel, a PhD psychologist who was chief of the program, received the news on January 14, 1972, a Friday. Over the weekend, unbeknown to Spiegel, paperwork was completed allowing the majority of the patients in the program to be discharged from the hospital. When he returned to work, Spiegel was asked by George Gillick, the physician who was Chief of Staff, to begin “evacuating” his patients into the community immediately. Gillick, who had been considering phasing out the restoration program even before the engineering test results were in, wanted the patients moved out quickly. However, because most of his patients were older single men without social or family ties to the community, satisfactory places for them to live outside of the hospital were not readily available. Nevertheless, on Wednesday, January 19, Gillick informed Spiegel that he was dissatisfied with the latter’s “lack of progress” and instructed him to discharge all the remaining patients within 1 week.

Spiegel was to discharge 5 patients that day, 10 the next day, 15 the day after that, and so on, so that before the end of the 7th day all 120 remaining patients would be out of the hospital. Spiegel, however, did not believe that he could meet these daily quotas without seriously jeopardizing the lives and well-being of his patients, particularly the elderly ones. Accordingly, 2 days later, on January 21, he asked Gillick during a staff meeting to reconsider the quota system. Gillick responded by summarily removing Spiegel from his position as Chief of the Adult Restoration Program and ordering him to report to the head of the psychology service for new duties. Later

the same day he appointed Edward O'Neil, a physician, as the new chief. In the meantime, someone informed a television reporter of what had happened, and that night Spiegel was shown on television criticizing the VA's hasty patient evacuation as he cleaned out his desk.

Having reported to the psychology service, Spiegel spent the next 5 days waiting for a new assignment. Finally, on January 26, he was detailed to the "women's cottage" to counsel women who were about to be discharged or transferred to a VA facility in Virginia. Again, it seemed to Spiegel that patients were being moved out of the hospital precipitously. Elderly women with serious medical problems who had lived at the hospital for many years were being uprooted suddenly. Convinced that the hospital's methods could lead to the deaths of some of these patients, Spiegel tried to have the procedures modified. When neither the hospital director nor chief of staff responded to his appeals, Spiegel appeared at a January 28 press conference arranged by the California State Psychological Association. Although agreeing that unsafe building conditions made it necessary to move the patients, Spiegel insisted that the "chaotic" manner in which their relocation was being carried out was as life threatening as another earthquake. He added, according to an article that appeared in the *Los Angeles Times* (Nelson, 1972) that psychologists were "concerned about a system which permits the imposition of administrative fiat on professional personnel for taking a stand against orders which would clearly damage patients or be detrimental to their welfare" (p. 1). Additional publicity was generated by patients who picketed the hospital in opposition to the relocations and Spiegel's removal from the restoration program.

O'Neil, meanwhile, continued evacuating Building 156. In contrast to Spiegel, he was given no quotas to meet, and (perhaps as a result of the publicity given Spiegel's charges) he was allowed to transfer some of the patients to other buildings on the hospital's grounds, an option not made available to Spiegel. By the beginning of March, the issue had become moot. All of the residents of Building 156 had been relocated and Spiegel, now attached to the psychology service, was at work on other projects. In addition, the final touches were being put on the administrative consolidation of Wadsworth Hospital and Extended Care Hospital into the Wadsworth Hospital Center that



had been occasioned by the decision to close some of the buildings and relocate the patients.

Then on March 8, 1972, 7 weeks after Spiegel had been relieved of his position with the restoration program, a teletype message arrived from the VA central office in Washington, B.C., ordering Spiegel to transfer to the VA hospital in Temple, Texas. The order indicated that the resettlement of many former Wadsworth Hospital Center patients to this installation required a reallocation of professional personnel "for the good of the service."

Spiegel, however, interpreted his transfer order as retaliation for his efforts to protect his patients. Since he had considerable seniority as an 18-year employee of the V A, any legitimate need for additional personnel at this facility, he reasoned, could have been accomplished by transferring any one of several other Wadsworth psychologists with less seniority. Moreover, transferring to Temple, Texas, a much less desirable location, would have caused a profound disruption in his personal and professional life. Consequently, he decided to fight the order. Seeking assistance in every available quarter, he contacted a number of groups including the California State Psychological Association, the American Psychological Association (APA), and the American Federation of Government Employees (AFGE), which filed a grievance in his behalf.

The VA responded to his protests by offering him a second choice. He was told that he could go to the Outpatient Clinic in downtown Los Angeles instead of transferring to Texas. Spiegel, who had spent the immediately preceding 13 years in a Research Psychologist position at Brentwood Hospital, discovered that his clinic responsibilities would involve providing full-time clinical services. In addition, he would be unable to continue working on a research project funded jointly by the VA and the National Institute of Mental Health of which he was the principal investigator. Accordingly, on March 22 he turned down the VA's second offer. The VA then promptly reinstated its original demand that he move to Temple, Texas, by May 1. Spiegel reiterated his unwillingness to relocate there, and so May 1 came and went and Spiegel remained in Los Angeles. As a result, on May 19 he was informed by John J. Cox,

Director of the VA's Southern California District, that he would be "separated" from the VA as of June 2, 1972.

The AFGE immediately filed an appeal to Cox's directive with the Civil Service Commission (CSC) charging that Spiegel's job rights had been violated. The CSC agreed to hold a hearing on Spiegel's appeal, but it was not until nearly 6 months later, on November 14, that the hearing was held. It lasted for 2 days. Testimony was taken from Spiegel, Gillick, Cox, and others, including Cecil Peck, PhD, the VA's head psychologist. Then 5 months later the CSC's San Francisco Regional Office ... ruled that the "arbitrary selection of the appellant for reassignment to the VA Hospital at Temple was improper" and overturned Spiegel's removal.

The VA appealed the decision of the regional office to the CSC's court of last resort, the Board of Appeals and Review. Unlike the regional office, the board did not deal with the question of whether the VA had violated certain procedural rules (e.g., seniority) in attempting to transfer Spiegel away from the Wadsworth Hospital Center. Instead, the board ... in effect ruled that a federal agency has the authority to take whatever actions "as may be administratively desirable" as long as the action is "for the good of the service." It decided, therefore, that Spiegel's transfer "was not unreasonable, arbitrary or capricious, but was effected for such cause as will promote the efficiency of the service" and overturned the decision of the regional office ....

Convinced of the merits of his case, Spiegel and the AFGE refused to accept the board decision. Accordingly, they decided to pursue the issue in the federal courts. After numerous delays, AFGE attorneys filed suit against the VA in the US Court of Claims in October 1974. Brought into the case for the first time, the Justice Department and the VA's own General Counsel's office advised that the VA should enter into negotiations with Spiegel's representatives. The VA agreed and action on the suit was postponed during the interim.

Finally, in February 1975, the VA agreed to an out-of-court settlement that reinstated Spiegel with full back pay and, in effect, acknowledged that it had acted wrongly in trying to transfer him. On March 2, 1975, nearly 3 full years after he refused to accept what he regarded as a punitive transfer, Spiegel returned to Brentwood Hospital.

## BUREAUCRATIC-PROFESSIONAL CONFLICT

Spiegel's battle with the VA is an engrossing story, but it is more than simply another tale of David and Goliath. It illustrates the need for further attention to a number of important issues that should be of concern to psychologists, individually and collectively. For instance, what are the ethical obligations of a psychologist whose employer and clients are locked in a conflict? What assistance—moral, political, or financial—is available to psychologists caught in a conflict of this sort? And how can psychologists maintain their *professional* standing when they abandon the traditional model of independent practice and become salaried employees?

It is important to realize, then, that the dispute between Spiegel and his VA superiors is fundamentally a conflict bureaucratic and professional values, especially the definition of authority. One of the distinguishing features of a bureaucracy is the hierarchical distribution of power and authority according to which subordinates are expected to follow the directives of their organizational superiors. A profession, on the other hand, is organized in a manner that emphasizes the autonomy of each individual member to act according to the dictates of his or her professional judgment. Consequently, when a professional is a salaried member of a bureaucracy, there is a necessary tension between the authority of the organization and the professional's own judgment (Blau & Scott, 1962). This tension may be kept in check by defining separate spheres of influence. Thus, professionals may accept the authority of the organization in, say, operational issues, such as the scheduling of client assignment. In return, the organization recognizes the right of professionals to decide, for instance, the type of treatment or service that is to be administered (cf. Abrahamson, 1967; Scott, 1969). In other words, although professionals may be subordinate to one another in organizational matters as a consequence of their different bureaucratic ranks, all are equal when it comes to matters of professional practice (e.g., patient care).

In refusing to move his patients out of the hospital as rapidly as the hospital director wished, Spiegel was asserting his professional autonomy and responsibility. In removing him as restoration program chief and later ordering him to another installation, the VA

was attempting to reassert its authority and ensure future conformity to its policies. However, because of legal assistance from the AFGE and the accessibility of the federal courts, the VA's effort failed. This case is worthy, therefore, not merely because professional judgment and organizational policy differed but because the professional prevailed in his refusal to comply with orders that violated his professional integrity. The implications of this conflict may be better appreciated by examining the issues and the responses of the key parties more closely.

## **THE TRANSFER**

Why was Spiegel ordered to Temple, Texas? According to the VA, there was an urgent need for another psychologist at Temple, since the Texas facility was in the process of receiving 102 patients from the Wadsworth Hospital Center and was already suffering from a vacant psychologist position. The agency's legal representative at Spiegel's CSC hearing maintained that "patient care was the primary and moving (sic) reason for the transfer of Dr. Spiegel to Temple" .... Spiegel did not contest the need for another psychologist at Temple, but he did not agree that he should be the one or that he was the most qualified. The VA, on the other hand, not only maintained that Spiegel was highly qualified for the post but that he was virtually without peers. Cecil Peck, who had accepted responsibility for selecting Spiegel to go to Texas, was asked by Spiegel's AFGE representative, George Boss, why he had chosen Spiegel and not someone else:

Boss: If there was such an urgent need for the specialized qualifications of a Research Psychologist, are you, in effect stating that there are no other Research Psychologists qualified to fill the job at Temple, Texas?

Peck: The position is open, and I'm not aware of any psychologists with the qualifications of Dr. Spiegel to fill that position.

Boss: Am I to understand that Dr. Spiegel is the only individual psychologist in the Veteran's Administration that's qualified to do this job in Temple, Texas?

Peck: That's what I have indicated; that Dr. Spiegel had qualifications that could optimally fit this situation ....

Cox ..., VA's Southern California District director, in his letter of appeal to the CSC Board of Appeals and Review chairman, provided 15 citations from the transcript of the CSC hearing that he indicated testified to Spiegel's "extraordinary combinations of skills."

Since Peck maintained that patient needs at Temple required the immediate attention of a well-qualified psychologist, Boss was puzzled that Peck had not assigned another psychologist to Temple after Spiegel was fired:

Then, in turn, would you explain why you have not selected another individual to fill the job in Temple, Texas? Peck: For the simple reason we are not aware of anyone with these qualifications to go there ....

In other words, Spiegel was ordered to Texas because he alone had the requisite qualifications to meet the needs of the Temple patients, and since, by definition, his talents were unique, there was no other VA psychologist that Peck could send to Temple. Spiegel and Boss found this reasoning "curious."

In his argument before the CSC hearing examiner, Boss pointed out several other curious aspects that appeared to contradict the VA's claim that patient care was "the moving reason" for Spiegel's transfer. First of all, following his refusal to go to Texas, Peck had offered Spiegel the alternative of moving to the Outpatient Clinic in downtown Los Angeles. If the Temple patients truly required Spiegel's talents, and his alone, why was he offered a transfer to the

Los Angeles clinic? The reason, according to Cox, was that the Los Angeles clinic also needed Spiegel's "unique and specialized qualifications" and that the VA central office felt a "sense of compassion" for the personal disruption transfer would cause Spiegel and his wife, a professor of psychology at San Fernando Valley State College .... Second, Peck's involvement in the transfer was highly unusual. VA administrators testified that transfers are typically initiated by the local administrative authorities, not the central office. In this case, however, the central office intervened directly and without consulting the administration of Wadsworth Hospital Center or the chief psychologist at either Temple or the Los Angeles Outpatient Clinic. Third, Boss pointed out that Spiegel could have been transferred back to Brentwood Hospital, his original station, but this alternative was rejected by the VA. Finally, Boss argued that the transfer of Elizabeth Hecht, a Wadsworth psychologist who had "volunteered" to go to Temple in order to avoid losing her job through a reduction in force, alleviated the need to send Spiegel there. (Later the AFGE would claim that the VA was attempting to transfer Spiegel to a supervisory position that was already "encumbered" by Hecht and another psychologist at Temple, a state of affairs definitely in violation of CSC regulations.)

If the VA's explanations for Spiegel's transfer were specious, what were the real reasons? According to Spiegel, it was a mixture of inter-professional rivalry and bureaucratic spleen. Spiegel was appointed Chief of the Adult Restoration Program by a social worker serving as hospital director in an acting capacity, who died shortly after making the appointment. About the same time, Gillick was appointed chief of staff. According to Spiegel, Gillick, a physician, was unhappy with the idea of a non-MD heading the restoration program (Spiegel's predecessor and successor were physicians), and therefore, he refused to approve Spiegel's position description and subsequently ousted him as restoration chief. His transfer, Spiegel charged, was in retaliation for his criticism of the hospital's administration and the unfavorable publicity that followed his removal. Spiegel felt that the VA was more interested in removing him from Extended Care Hospital (later Wadsworth Hospital Center) and in punishing him for his public dissent than it was in meeting its personnel requirements.

Spiegel's charge that his public criticism of the VA was related to his transfer order was flatly denied by VA officials. Peck has testified that the news stories did not influence his judgment in proposing Spiegel's transfer. He and other VA officials acknowledged that they were aware of the media reports relating Spiegel's criticism, but they insisted that they maintained a detached attitude toward these reports, as indicated by this exchange between Cox and Boss:

Boss: What was the substance of your discussion with the VACO [VA central office] concerning that article in the paper?

Cox: If I recall correctly, I believe in my discussion with officials in Washington it was to the effect that with all the trauma that we were going through out here in transferring our patients to various parts of the country, we didn't need further articles of this type to disrupt our patients any further.

Boss: Then your discussion was critical of the information furnished by Dr. Spiegel to the press?

Cox: I wouldn't call it critical. I would say it was *informative* ....

In addition to questioning the cogency of the VA's explanations for his transfer, Spiegel also challenged the procedural legitimacy of the actions taken against him. He claimed that his removal as head of the restoration program constituted a "reduction in rank" since he no longer reported directly to the chief of staff. And as this change was accomplished without the usual elements of due process that are called for by CSC regulations, he argued that it should be considered invalid. For similar reasons, he maintained that his transfer to Texas violated both "reduction-in-rank" (since again he would be one level further down the organizational chain of command) and "reduction-in-force" regulations—the latter because he had been given no opportunity to exercise his right to "bump" someone of lower seniority. Therefore, since the VA had acted improperly, he argued, these adverse actions should be nullified.

## LEGAL MANEUVERS

The formal discussions of these points are not only arcane and exceedingly technical, they have a distinctly Alice-in-Wonderland

quality. For instance, the VA argued that Spiegel's rank was not reduced because he had never "really" been restoration chief. The VA's position was that even though: (a) Extended Care Hospital distributed a memo announcing Spiegel's appointment as Chief of the Adult Restoration Program; (b) the hospital director signed an organizational chart which showed that Spiegel reported directly to the chief of staff (Gillick); and (c) Spiegel in fact functioned as restoration chief for approximately 6 months, Spiegel's supervisor (Gillick) had never signed his official position description. Since CSC regulations require all government employees to have an approved position description relevant to their duties, the VA claimed that Spiegel had never legally been restoration chief. Therefore, they argued, they could not have improperly reduced his rank since he had never truly held the chiefs position.

Furthermore, the fact that Gillick did not issue a personnel action (Form 50) when he removed Spiegel was cited as additional evidence that Spiegel had never occupied a rank higher than "psychologist." (Spiegel, of course, felt that this omission merely represented an additional violation of his job rights.) According to the federal suit filed by the AFGE ..., this line of reasoning would be tantamount to arguing that a municipality could never prosecute someone for driving without a license because driving is legally defined as "an action which requires the issuance of a driver's license."

Spiegel's lawyers, however, were not unwilling to turn this tortured logic to the benefit of their client. Thus, they argued that if it were true that Spiegel had never truly been chief at Extended Care Hospital because he did not have a duly signed position description for his duties there, it must also be true that his transfer from his original position ("research psychologist") at Brentwood had never been consummated. Therefore, the VA's termination order was procedurally defective since it fired him from a position that he had never held (i.e., "psychologist" at Extended Care Hospital).

An even more bizarre twist developed over the grievance that had been lodged in Spiegel's behalf by the AFGE shortly after Gillick removed him as restoration chief. The grievance was filed by William McPeak, an AFGE official, in a letter to Jaffrey, Director of Wadsworth Hospital Center. Unfortunately, a few days after writing



Jaffrey, McPeak died. Jaffrey then decided not to follow up on the grievance on the grounds that the VA did not “know” who now exercised Spiegel’s power of attorney. Later, after the period for filing a grievance had passed and in response to the union’s insistence that something be done about Spiegel’s grievance, Jaffrey wrote a letter to the (deceased) McPeak citing his demise as the reason for the hospital’s failure to act on the grievance. This state of affairs led the CSC San Francisco Regional Office ... to rule “the fact that the appellant’s representative died within a few days after writing the letter does not absolve the agency of their responsibility to take some positive and affirmative action on this grievance.”

Like its answer to Spiegel’s charges that he had been improperly reduced in rank, the VA’s response to the charge that it had violated his rights under reduction-in-force regulations was based on a highly technical interpretation of the facts. VA officials acknowledged that a reorganization was underway at the time that Spiegel was ordered to Texas. They also acknowledged that “general” notices were sent in February 1972 to over 700 employees announcing that there would be a reduction in the number of staff needed at Wadsworth, and that several psychologists (not including Spiegel and others with high seniority) received these notices. In addition, they acknowledged that the personnel officer had indicated “unofficially” in the employee’s newsletter that there were eight “surplus” psychologists.

Following these announcements, one psychologist applied for retirement, two resigned, and six (including Elizabeth Hecht, who went to Temple, and two who went to Brentwood) transferred to other stations. As a result of these individual moves, the VA claimed that the problem of “surplus” psychologists was solved without resort to the issuance of individual reduction-in-force notices. And since individual notices had never been issued, the VA argued that a reduction in force did not formally exist in the Psychology Service by the time that the central office transmitted its order for Spiegel to transfer to Texas.

The CSC Board of Appeals and Review, which has come under attack for adopting a reflexively “pro-management” position (cf. Vaughn, 1975), accepted all of the VA’s contentions. Overruling the regional office, the board decided that the VA had not violated CSC reduction-

in-force procedures in ordering Spiegel to move to Texas or to leave the service, and it agreed with the VA that Spiegel had not suffered a reduction in rank. Accordingly, it refused to order the VA to reinstate Spiegel.

At this point Spiegel and the AFGE went into federal court. They repeated their claims that the VA's actions toward Spiegel were punitive and in violation of CSC regulations. They also charged that the CSC board's decision represented "an improper, arbitrary and capricious interpretation of the Federal Personnel Manual in violation of the ... US Constitution" .... Shortly thereafter the VA contacted Spiegel's representatives to seek an out-of-court settlement. No official explanation of this decision has been offered; however, VA officials (who have asked not to be identified) have indicated that the reason for this change in position was the agency's belated realization that the actions taken against Spiegel had been improper, and they didn't think that their case would stand up in court.

Although Spiegel has now won his job back, the basic issues remain unresolved. There have been no changes in policies governing professional roles in the VA or administrative discretion in ordering transfers. As a result, according to Dale Tresidder ..., Director of the VA Evaluation and Systems Service in Washington, "It could happen all over again."

## **THE PROFESSION'S RESPONSE**

Spiegel's abrupt dismissal as Chief of the Adult Restoration Program came at a time when the public was just becoming aware of [California's] plan to close down the state's mental hospitals. Only 2 days before, the California State Employees Association had released a 17-page report charging that thousands of people had been dumped out of state hospitals into unequipped "board and care" homes or hotels for transients (Endicott, 1972). According to Karl Pottharst ..., President of the California State Psychological Association (GSPA) at the time, the CSPA Board of Directors were concerned about the apparent breakdown in mental health care. They had, for example, decided to join a lobbying effort at the state capitol to halt further hospital closings. Pottharst, however, felt that more was required. He

wanted “to find some way to bring to public attention the barely visible plight of mental patients” who were being precipitously pushed out of state hospitals .... Despite assurance of CSPA moral support, efforts to encourage some of the psychologists in the state system to speak out publicly were unsuccessful because the latter were afraid that they would be transferred or lose their jobs if they did. Consequently, upon learning of Spiegel’s ouster, Pottharst immediately contacted him and asked him to appear at a news conference called by CSPA and to describe the plight of his patients.

According to Pottharst, another problem in addition to job insecurity that impeded the mobilization of the state-employed psychologists was the lack of clearly defined ethical principles and precedents. Neither the *Ethical Standards of Psychologists* (APA, 1972a) nor the *Guidelines for Conditions of Employment for Psychologists* (APA, 1972b) seemed to provide clear direction to psychologists torn between loyalty to their clients and loyalty to their employer. Accordingly, Pottharst ... wrote to Richard Brooks, then Chairman of the CPA Committee on Ethics and Professional Responsibility, to charge the committee “with the task of defining a professionally responsible and ethical position with regard to the issues raised in this situation (i.e., patient dumping) in time for reporting to the CSPA Board of Directors at its June meeting.” The committee, however, did not carry out this mandate.

Pottharst wrote a number of other letters during this period concerning Spiegel. Included among these was a letter to S. Don Schultz, then Chairman of the APA Board of Professional Affairs asking that the board direct its Committee on Academic Freedom and Conditions of Employment (CAFCE) to investigate what had happened to Spiegel. Schultz ... wrote back that it would be best if Spiegel himself filed a complaint with CAFCE and requested an investigation. He also suggested that Pottharst formally request the Task Force on Standards for Providers of Psychological Services to review the situation. However, he expressed doubt that either unit would be able to take action prior to the board’s next meeting, 2 months away. This turned out to be the case. Although Schultz did inform the board of his correspondence with Pottharst, it took no action.

Spiegel, meanwhile, had acted upon Schultz's advice and had filed a complaint with CAFCOE, which by this time included the issue of his transfer in addition to his removal as restoration chief. Although F. Nowell Jones, Chairman of CAFCOE, called him several times shortly after he submitted his complaint, Spiegel soon began to doubt the wisdom of having requested APA's intervention. Overall, APA seemed unresponsive and ineffectual, and its procedures for handling his grievance seemed slow and cumbersome. Finally, fearing the CAFCOE's investigators might lack the experience or skill to get at the truth or would interfere in some way with the defense being prepared by his lawyers, Spiegel decided to disengage himself from the committee. Consequently, when APA Central Office staff wrote requesting information and indicated that his case would be considered closed unless this information was received, he did not respond. Inexplicably, he failed to give his reason and APA, for its part, did not inquire into it. The committee ... simply voted to close the case.

## **THE LONELINESS OF WHISTLE BLOWING**

The reaction of the other hospital employees has left Spiegel nonplussed. After he was ordered to Texas, but before he was actually separated, Spiegel reported that many staff people would come up to him to express their support and to "leak" information to him on what the administration was planning next. When he returned to his job, many people came up to congratulate him and to tell him how happy they were that a person could successfully stand up to *them*. Despite the positive reception that he received upon his return and prior to his leaving, none of the staff contacted him during his hiatus. "I assumed that the people who are tied into the system were afraid, but I really don't know," he says ....

Had it not been for George Katz, a Wadsworth psychologist fired along with Spiegel when he too refused to accept a transfer, and the AFGE, Spiegel indicated that it would have been very difficult psychologically. He and Katz were in frequent contact comparing their similar situations. The AFGE, he said ... was "really marvelous. There was always someone there you could talk to. And they were always willing to try something." (Spiegel had not always been a

union supporter. It wasn't until after he had received his transfer order and had received the immediate backing of local union representatives that he joined the union.)

In view of the publicity surrounding his case and the considerable brouhaha that it generated, Spiegel assumed that everyone would have known about it. Not so. Soon after his return to the hospital after an absence of nearly 3 years, he ran into an old colleague. "Where have you been?" the other researcher asked, "I haven't seen you around in a while."

## Notes

- \* — Source: Adapted from Simon, G. C. (1978). The psychologist as whistle blower: A case study. *Professional Psychology*, 9(2), 322–340. Copyright 1978 by the American Psychological Association (APA). Adapted with permission.

## **Part II**

# **COMMON SOURCES OF PROBLEMS**

# Chapter 10

## ETHICS, SCIENCE, AND PSEUDOSCIENCE

Psychotherapy is an art which uses the tools of science to guide us toward interventions likely to help a particular person. Science also helps prevent us from using interventions that may be harmful, too risky, or a waste of time for our clients. A fundamental psychotherapy ethic is to keep our work grounded in science. For instance, the APA code emphasizes: “Psychologists’ work is based upon established scientific and professional knowledge of the discipline” (APA, 2017a, section 2.04). Similarly, the CPA (2017a) code reminds us that psychologists “keep themselves up to date with a broad range of relevant knowledge, research methods, and techniques, and their impact on persons and society, through the reading of relevant literature, peer consultation, and continuing education activities, in order that their service or research activities and conclusions will benefit and not harm others” (section II9).

Keeping up to date with the science is not an easy task. Our knowledge quickly becomes obsolete at the hands of new research that disproves what we thought was true, guides new interpretations, and reveals better or different ways of helping people. Our field’s wealth of journals, each constantly releasing new articles, contributes to this rapid rate of change.

Almost a half-century ago, Dubin (1972) noted that the “outpouring of publications [in psychology] creates an obsolescence situation of staggering proportions” (p. 487). He estimated that the half-life of what psychologists know at any given time is around 10–12 years and recommended that about 20% of a professional’s time should be devoted to updating their fund of knowledge. We will pause here until most therapists finish laughing. We also answer the question that may have popped into readers’ minds: No, Dubin’s article did

not tell therapists where they could find the extra time in their schedules to do this updating.

As the field continues to grow, research increases, new journals sprout, and the half-life of our knowledge continues to shrink. Neimeyer et al. (2012), for example, reported a Delphi Poll suggesting that “the expected half-life of knowledge in professional psychology was expected to shrink from its current level of 8.80 years to 7.07 years within the next 10 years. This represents a predicted 20% decrease over the course of the next decade” (p. 368).

A follow-up study found the overall durability of knowledge across all areas within specialties in professional psychology varied from a high of 18.37 years (psychoanalysis) to a low of 7.58 years (clinical health psychology), with the overall durability of knowledge across all areas being 8.68 years (Neimeyer et al., 2014). The speed of change suggests that what we are learning in our graduate studies today may, if not updated throughout our career, leave us unprepared to provide the most safe and effective services to our patients (Chor et al., 2014; Washburn et al., 2019).

Another challenge we face is the growing tendency of enthusiastically promoted “landmark,” “cutting edge,” and “revolutionary” theories to avoid adequate testing against other theories that might better explain the data. Bruce Bower (2013) wrote:

In its idealized form, science resembles a championship boxing match. Theories square off .... Under the stern eyes of a host of referees, one theory triumphs by best explaining available evidence—at least until the next bout. But in the real world, science sometimes works more like a fashion show. Researchers clothe plausible explanations of experimental findings in glittery statistical suits and gowns. These gussied-up hypotheses charm journal editors and attract media coverage with carefully orchestrated runway struts, never having to battle competitors.

It is not just that we often get the first word—often making a lasting impact—of new “findings” from press releases, news articles (which may quote only supporters), and television segments. Researchers tend to avoid competing theories, focusing closely on experimental data and statistical tests of their own favored theory. Walter Mischel



(2008) referred to this tendency as the *toothbrush problem*: “Psychologists treat other peoples’ theories like toothbrushes—no self-respecting person wants to use anyone else’s .... Even the structure of our disciplines and sub-disciplines, are rooted in what made sense a century ago when psychology departments formed, feed the toothbrush drive and undermine current efforts to build a cumulative psychological science.”

Fiedler et al. (2012) noted our field’s unfortunate emphasis on “statistical tests of causal models (while ignoring alternative theoretical models)” (p. 664). They cite the story of Clever Hans, a horse that had repeatedly demonstrated in various tests an apparent ability to perform mathematical calculations:

“Even the most compelling evidence (large  $n$ , small  $a$ ) that the horse named Hans provided correct responses to calculation tasks could not prove that the horse could do math in its head. The genius of Oskar Pfungst (Pfungst, Stumpf, & Rahn, 1911) was to consider  $\beta$  errors. He tested Hans under novel conditions (e.g., varying the testers’ body language) that others—among them famed psychologist Carl Stumpf—had not dreamed of as being relevant.” (p. 664)

Another challenge sounds like an old-time horror movie title: *The Myth That Will Not Die!* Some theories, studies, and approaches that have been discredited continue to live on and mislead us. We meet these myths in secondary sources, lectures, and expert testimony, but often don’t have the time or the desire to find and read the original source. As a result, we take the statements provided by others in secondary sources as facts. Olio and Cornell (1998) described these as *academic urban legends*. They provided detailed documentation to demonstrate how an “imperfect narrative ... and pseudoscientific conclusions have been uncritically accepted and repeated in the literature, thus becoming an academic version of an urban legend” (p. 1195). Rekdal (2014) subsequently described what happened when these hardy academic urban legends met the internet and computerized databases:

The digital revolution has certainly made it easier to expose and debunk myths, but it has also created opportunities for new and remarkably efficient academic shortcuts, highly attractive and tempting not just in milieus characterized by increasing publication pressure and more concerned with quantity than quality, but also for groups and individuals strongly involved in rhetorics of demarcation of science, but less concerned with following the scientific principles they claim to defend. Some academic urban legends may perish in the new digital academic environment, but others will thrive and have ideal conditions for explosive growth. (p. 651)

Many of these myths not only survive repeated debunking but continue to thrive. To illustrate, Lilienfeld et al. (2015) note that “repeatedly stating that a claim is incorrect can, paradoxically, generate a ‘familiarity backfire effect,’ whereby the claim comes to be accepted as true merely because it has been heard many times.”

An active approach can help ground us in the current science: actively seek out new theory, research, and practices relevant to our work; actively read and listen to critics of our own current beliefs and practices; actively question new claims (Pope, 1996, 1997, 1998). In addition, when integrating known theories into our work, it is important to read the original sources rather than rely on the description and interpretation of others (i.e., secondary sources).

Open, active, constant questioning of all new claims is as important as seeking them out. “Uncritical acceptance of scientific claims may be as damaging as reflexive rejection. Science, policy, and education suffer when the vigorous authoritative promotion of claims fails to meet vigorous critical examination” (Pope, 1996, p. 957). Some claims flourish free of rigorous questioning because they enjoy the support of prevailing scientific paradigms, historical contexts, influential sponsors, and the bandwagon effect (Mednick, 1989; Pope, 1996, 1997, 1998) or because they have been picked-up by the news or social media. Making sure no claims escape critical evaluation can begin by asking the basic questions we learned in graduate school for each new study. Here are some examples:

- Are we evaluating the study itself or an abstract, press release, or second-hand account? There can be quite a bit of slippage,

exaggeration, and missing information in the latter three. Assem et al. (2017), for example, conducted a meta-analysis comparing the content of the abstracts to the full-text reports of 350 randomized controlled trials [RCT] that included 8,258 outcomes. They found that abstracts were *significantly* biased toward significant outcomes. For instance, an “RCT abstract had three times the odds of being significant when compared to the corresponding full text (OR = 3.0, 95% confidence interval 2.5–3.6,  $p < 0.001$ ). This finding was consistent and not subject to heterogeneity ( $I^2 = 0\%$ )” (p. 194; see also Nascimento et al., 2019). Nascimento and her colleagues compared the abstracts of 66 systematic reviews to the full-text reports and found that 80% of the abstracts included spin and were inconsistent with the full report (Nascimento et al., 2019). A wealth of studies show how misleading abstracts can be. At least that’s what their abstracts suggest.

- How many participants? Were there enough for the statistical power of the inferential statistics?
- How were the participants selected? A random sample? A sample of convenience? A call for volunteers posted on the internet? A call for volunteers in an undergraduate introductory psychology course?
- How representative were the participants for the particular study? For the study’s stated purposes, conclusions, and claims were there any limitations or potential biasing factors such as age, gender, race, ethnicity, culture, background, language, sexual orientation, or physical or mental abilities and disabilities? This is a question we must also ask when we weigh the relevance and validity of a study, intervention, or assessment instrument for a particular client. The original MMPI, for example, included in its normative sample only White people, most of whom lived on or near small farms or small towns in the US Midwest. Unsurprisingly, this instrument produced invalid results for Black, Indigenous People of Color (BIPOC). One widely-used computerized MMPI scoring and interpretation service incorrectly classified 90% of a group of the apparently

normal Black test-takers as showing profiles typical of psychiatric patients (Erdberg, 1988; Pope, Butcher et al., 2006).

- Did the study do a good job of exploring potential confounding factors? Were the factors *explicitly* identified, discussed, and taken account of in the design of and inferences drawn from the study? Can you think of any that might have been missed?
- Did the interpretation of the results mistake correlation for causation? Few cautions are so well-known in our field and yet it is surprising how often this confusion sneaks into the research reports.
- Could the study's funding or sponsorship have played an unfortunate role in framing the hypotheses, choosing measures or comparison groups, selecting the statistical tests, or reporting the results? For example, meta-analyses and other systematic reviews have found that drug studies that are sponsored by the drug's manufacturer are associated with significantly more favorable results for the sponsor's drug than drug studies that are independently sponsored (see, e.g., Bhandari et al., 2004; Flacco et al., 2015; Jefferson, 2020; Kelly et al., 2006; Krauth et al., 2014; Lexchin et al., 2003; Lundh et al., 2012; Wang et al., 2018).
- Has the study been independently replicated? Recently, psychology has been undergoing a "replication crisis" (Frost, Baskin, & Wampold, 2020; Hengartner, 2018; Lilienfeld, 2017; Shrout & Rodgers, 2018; Tackett et al., 2019). Especially when so many studies fail to replicate independently, it makes sense to evaluate what independent evidence—published by a different lab or different authors—if any, there is to support a published finding.
- For qualitative studies, have you ensured methodological integrity and described the process to the public? Levitt et al. (2018) describe two standards to ensure methodological integrity including: (a) fidelity to the subject matter; and (b) utility in achieving research goals which are described in four central features. They explain that "Fidelity to the subject matter is the process by which researchers select procedures that develop and maintain allegiance to the phenomenon under study as it is conceived within their approach to inquiry (e.g., the phenomenon

might be understood as a social construction). It is improved when researchers collect data from sources that can shed light upon variations in the phenomenon that are relevant to the research goals (1. data adequacy); when they recognize and are transparent about the influence of their own perspectives and appropriately limit that influence within data collection (2. perspective management in data collection); when they consider how these perspectives influenced or guided their analytic process in order to enhance their perceptiveness (3. perspective management in data analysis); and when findings are rooted in data that support them (4. groundedness)” (Levitt et al., 2018, p. 33; see also Appelbaum et al., 2018; Levitt et al., 2020).

- Several qualitative methods use an iterative approach that allows for researchers to alter existing questions and/or add new prompts for research participants to answer. This method also allows for researchers to be in contact with participants more than once. Given the dynamic nature of the procedures in several qualitative methodologies “extensive interpersonal contact with participants can mean that research ethics within a study require continual reconsideration” (Levitt et al., 2018, p. 29). Qualitative researchers are encouraged to use a process-oriented approach to ethical decision-making grounded in trustworthiness and professional reflexivity (Haverkamp, 2005; Josselson, 2007). Such process considers the following: How did the research team navigate changes to the research protocol? What prompted the change? Did you consult with an auditor about edits and additions to the research protocol? Were you transparent about any shifts in the protocol when communicating your findings? Did you consider your positionality and how this may have impacted your results?

The next four chapters expand the discussion of critical thinking beyond this chapter’s focus on research. Those chapters—“Ethical Fallacies,” “Pitfalls in Ethical Cognition,” “Language and Ethics,” and “Ethics Placebos, Rationalizations, and Excuses”—focus on areas of critical thinking we can use to strengthen our ethical decision-making.

# Chapter 11

## ETHICAL FALLACIES<sup>1</sup>

Logical fallacies trip up all of us at one time or another. They sneak up in camouflage. They hide in the background, blending in with some of our best reasoning. They fool us with misdirection. We fall for their dazzling demonstrations that adding apples and oranges equals somewhere in the neighborhood of green beans.

Below we provide 26 illustrations of logical fallacies—each with a brief description and an example—that can send ethical reasoning off track, sometimes ending in disaster. It is critical for us to remember that nobody is magically immune to them. We all fall for them if we're not on alert.

### 1. AD HOC RATIONALIZATION

In this fallacy, we invent on the spot, a factor that explains away evidence or arguments that counter our views, beliefs, or claims.

#### Example

Dr. A: My paper and pencil test of intelligence is better than any of the others.

Dr. B: But in that recent study, it showed no reliability or validity.

Dr. A: I'm sure they scored it incorrectly.

Dr. B: They brought in two other teams to make sure the scoring was done correctly.

Dr. A: The researcher was probably one of my rivals, someone who wanted to do me wrong.

Dr. B: Actually, it's your best friend who has been your biggest supporter for decades.

Dr. A: Oh yeah? No wonder! He had to lean over backwards to make my test look bad so that he wouldn't be accused of favoritism!

## **2. Ad Hominem or Ad Feminam**

In the argumentum ad hominem or ad feminam we try to discredit a claim by drawing attention to the characteristics of the person who is making the claim, even though the two are unrelated.

### **Example**

“The research and reasoning that supposedly supports this intervention are a joke. The researchers are people who are not methodologically sophisticated and there have been rumors—I have no idea whether they're true or not; we'll just have to wait and see—that they faked some of the data. Fans of this intervention are the worst kind of sloppy thinkers. They are closed-minded fanatical adherents who've become true believers in a cause. They make arguments only a stupid person would accept. Their mistakes in reasoning would make an undergrad psych major blush. These are not the kind of people who deserve to be taken seriously and we should waste no time examining their so-called evidence and arguments.”

## **3. AFFIRMING THE CONSEQUENT**

This fallacy takes the form of:

If  $x$ , then  $y$ .

$y$ .

therefore:  $x$ .

### **Example**

“People who are psychotic act in a bizarre manner. This person acts in a bizarre manner. Therefore: This person is psychotic.”

Another example: “If this client is competent to stand trial, she will certainly know the answers to at least 80% of the questions on this

standardized test. She knows the answers to 87% of the test questions. Therefore, she is competent to stand trial.”

#### **4. APPEAL TO IGNORANCE (AD IGNORANTIAM)**

The appeal to ignorance fallacy takes the form of:

There is no (or insufficient) evidence establishing that x is false.

Therefore: x is true.

#### **Example**

“In the six years that I have been practicing my new and improved brand of cognitive-humanistic-dynamic-behavioral-deconstructive-metaregressive-deontological-neuroenhancing psychotherapy (now with biofeedback!), which I developed, there has not been one published study showing that it fails to work or that it has ever harmed a patient. It is clearly one of the safest and most effective interventions ever devised.”

#### **5. ARGUMENT TO LOGIC (ARGUMENTUM AD LOGICAM)**

The argument to logic fallacy takes the form of assuming that a claim must be false because an argument offered in support of the claim was fallacious.

#### **Example**

“This new test seemed so promising, but the 3 studies that supported its validity turned out to have critical methodological flaws, so the test is probably not valid.”

#### **6. BEGGING THE QUESTION (PETITIO PRINCIPII)**

This fallacy, one of the fallacies of circularity, takes the form of arguments or other statements that simply assume or re-state their



own truth rather than providing relevant evidence and logical arguments.

## **Examples**

Sometimes this fallacy literally takes the form of a question, such as, “Has your psychology department stopped teaching that ineffective approach to therapy yet?” (The question assumes—and a “yes” or “no” response to the question affirms—that the approach is ineffective.) Or: “Why must you always take positions that are so unscientific?” (The question assumes that all of the person’s positions are unscientific.) Sometimes this fallacy takes the form of a statement like “No one can deny that my theoretical orientation is the only valid theoretical orientation” or “It must be acknowledged that the neuropsychological test battery I use is the only legitimate test battery.” Sometimes it takes the form of a logical argument, such as, “My new method of conducting meta-analyses is the most valid out there because it is the only one capable of such validity, the only one that has ever approached such validity, and the only one that is so completely valid.”

## **7. COMPOSITION FALLACY**

This fallacy takes the form of assuming that a group possesses the characteristics of its individual members.

### **Example**

“Several years ago, a group of ten psychologists started a psychology training program. Each of those psychologists is efficient, effective, and highly regarded. Their training program must be efficient, effective, and highly regarded.”

## **8. DENYING THE ANTECEDENT**

This fallacy takes the form of:

If x, then y.

Not x.

therefore: not y.

## **Example**

“If this test was based on fraudulent norms, then it would be invalid. But the norms are not fraudulent. Therefore, this test is valid.”

## **9. DISJUNCTIVE FALLACY**

This fallacy takes the form of:

Either x or y.

x.

Therefore: not y.

## **Example**

“These test results are clearly wrong, and it must be either because the client was malingering or because I bungled the test administration. After taking another look at the test manual, I see now that I bungled the test administration. Therefore, the client was not malingering.”

## **10. DIVISION FALLACY OR DECOMPOSITION FALLACY**

The division fallacy or decomposition fallacy takes the form of assuming that the members of a group possess the characteristics of the group.

## **Example**

“This clinic sure makes a lot of money. Each of the psychologists who work there must earn a large income.”

## **11. EXISTENTIAL FALLACY**

The existential fallacy begins with two universal premises and draws a specific conclusion from them. The two premises may be true, but that does not logically establish the existence of any members in the categories they represent.

### **Example**

In my practice, I currently have all the patients in this town who are willing and able to pay \$5,000 per session for long-term twice-weekly therapy. If you buy my practice, all my clients will be included. Therefore, if you buy my practice, you will then have at least some patients willing and able to pay \$5,000 per session for long-term twice-weekly therapy.

## **12. FALSE ANALOGY**

The false or faulty analogy fallacy takes the form of argument by analogy in which the comparison is misleading in at least one important aspect.

### **Example**

“There were wonderful psychologists who passed away several decades ago. If they could be effective in what they did without reading any of the studies or other articles that have been published in the last several decades, there’s no need for me to read any of those works in order to be effective.”

## **13. FALSE CONTINUUM**

In this fallacy, the absence of a clear, definitive marker separating a continuum into two mutually exclusive groups is used to falsely prove that there is no difference between the two extremes on the continuum.

### **Example**

“In many cases you can’t really tell whether patients are improving because of what the therapist is doing or because of the placebo effect—there’s a fuzzy line separating the two—so we must conclude that they are actually the same mechanism of improvement.”

## **14. FALSE DILEMMA**

Also known as the “either/or” fallacy or the fallacy of false choices, this fallacy takes the form of acknowledging only two options (one of which is usually extreme) from a continuum or other array of possibilities.

### **Example**

“Either we accept the findings of this study demonstrating that this new intervention is the best to be used for this disorder, or we must no longer call ourselves scientists, psychologists, or reasonable people.”

## **15. FALSE EQUIVALENCE**

In this fallacy, the fact that two items share a characteristic or are linked by some similarity demonstrates that they are equivalent.

### **Example**

“Most of my testimony about the defendant was the opposite of what I actually believe but I’ll bet there are no other expert witnesses who have told the truth every single time. From the time they were old enough to talk, we all lie, so I’m no less honest than anybody else.”

## **16. GENETIC FALLACY**

In this fallacy, whether a proposition is true or false is deduced or inferred from the proposition’s origin.

### **Examples**

This theory originally occurred to a scientist in the form of a dream; therefore, it cannot be valid. Or: Since it was a deathbed confession, it must be true.

## **17. GOLDEN MEAN FALLACY**

The fallacy of the Golden Mean (or fallacy of compromise, or fallacy of moderation) takes the form of assuming that the most valid conclusion is that which accepts the best compromise between two competing positions.

### **Example**

“In our psychology department, half of the faculty believe that a behavioral approach is the only valid approach; the other half believe that the only valid approach is psychodynamic. Obviously the most valid approach must be one that incorporates both behavioral and psychodynamic elements.”

## **18. IGNORATIO ELENCHI**

This fallacy takes the form of assuming that an argument, whether or not internally valid, proves a particular point when in fact it misses the point of the issue.

### **Examples**

“There is zero doubt that she has the condition. She scored high on two separate diagnostic tests and both tests have shown extremely high validity. That proves she has it.” Or: “I don’t see how you can believe he is not guilty of that crime. He’s a terrible person and I can prove it. In fact, several years ago he was convicted of that same kind of crime.”

## **19. MISTAKING DEDUCTIVE VALIDITY FOR TRUTH**

This fallacy takes the form of assuming that because an argument is a logical syllogism, therefore the conclusion must be true. It ignores the possibility that the premises of the argument may be false.

## **Example**

“I just read a book that proves that that book’s author can do much better than any psychological test at finding out if someone is malingering. The book’s author reviews the literature showing that no psychological test is perfect at identifying malingering. All have at least some false positives and false negatives. But the author has a new method of identifying malingerers. All he does is listen to the sound of their voice as they say a sentence or two. And he included in the book a chart showing that by using this method he has never been wrong in hundreds of cases. That proves his method is better than using psychological tests.”

## **20. NATURALISTIC FALLACY**

The naturalistic fallacy takes the form of logically deducing values (e.g., what is good, best, right, ethical, or moral) based only on statements of fact.

## **Example**

“There is no intervention for victims of domestic violence that has more empirical support from controlled studies than this one. It is clear that this is the right way to address this problem and we should all be providing this therapy whenever victims of domestic violence come to us for help.”

## **21. NOMINAL FALLACY**

The nominal fallacy is the mistake of assuming that because we have given a name to something, therefore we have explained it.

## **Example**

Therapist A: “I just don’t care about my patients anymore. I don’t pay attention to what they say. I show up late for sessions. I don’t care if they show up. I ask them if they’d rather we just use the session for playing a game of tennis or sharing a cup of coffee. I don’t keep records.”

Therapist B: “You have a classic case of burn-out!”

Therapist A: “But why am I doing all these things?”

Therapist B: “Because you’re burned out.”

## **22. POST HOC, ERGO PROPTER HOC (AFTER THIS, THEREFORE ON ACCOUNT OF THIS)**

The post hoc, ergo propter hoc fallacy takes the form of confusing correlation with causation and concluding that because Y follows X, then Y must be a result of X.

### **Example**

“My new sport psychology intervention works! I chose the player with the lowest batting average based on the last game from each of the teams in our amateur baseball league. Then I gave each of them my 5-minute intervention. And almost all of them improved their batting average in the next game!” (Note: this example may also involve the statistical phenomenon of regression to the mean.)

## **23. RED HERRING**

This fallacy takes the form of introducing or focusing on irrelevant information to mislead the audience by distracting them from the valid evidence and reasoning. (It is this specific intent to mislead that sets it apart from the ignoratio elenchi fallacy.) It takes its name from the strategy of dragging a herring or other fish across the path to distract hounds and other tracking dogs and to throw them off the scent of whatever they were searching for.

### **Example**

“Some of you have objected to the new test batteries that were purchased for our program, alleging that they have no demonstrable validity, were not adequately normed for the kind of clients we see, and can’t be used with clients who are physically disabled. What you have conveniently failed to mention, however, is that they cost less than a third of the price for the other tests we had been using, are much easier to learn, and can be administered and scored in less than half the time of the tests we used to use.”

## **24. SLIPPERY SLOPE (ALSO KNOWN AS “THE CAMEL’S NOSE FALLACY”)**

The slippery slope fallacy is a form of the Non Causa Pro Causa (mistaking a non-cause as a cause) and the non sequitur (it does not follow), which claims (without proof) that A inevitably must cause B, and B can have no other outcome than C, and C is sufficient cause for D, and D must lead to E, and E must produce F, and so on, and because the last link in the supposedly causal chain is undesirable, therefore the first step is undesirable.

### **Examples**

“If the government allows psychologists to prescribe medications there will be no basis to block them from obtaining competence and legal authority to conduct other traditionally medical procedures such as diagnosing minor skin irritations, treating a sprained ankle, setting a broken bone, and performing neurosurgery.” Or: “Never reduce a fee for any patient for any reason or else you’ll find yourself constantly reducing fees for everyone, everyone will take advantage of you, your patients will lose respect for you and for therapy, and you’ll lose money and go bankrupt.”

## **25. STRAW PERSON**

The straw person, or straw man, straw woman, or straw group fallacy takes the form of mischaracterizing someone else’s position in a way that makes it weaker, false, or ridiculous.



## Example

“Those who believe in behavior modification obviously want to try to control everyone by subjecting them to rewards and punishments.”

## 26. YOU TOO! (TU QUOQUE)

This fallacy takes the form of distracting attention from error or weakness by claiming that an opposing argument, person, or position has the same error or weakness.

## Example

“I have been accused of using an ad hominem approach in trying to defend my research. But those who attack my research and me are also using ad hominem. And they started it!”

<sup>1</sup>This chapter is adapted from “Common Logical Fallacies in Psychology: 26 Types & Examples” by Kenneth S. Pope, Ph.D., ABPP. [© copyright K.S. Pope, 2012, 2014]. It is available online at <http://kspope.com/fallacies>.

# Chapter 12

## PITFALLS IN ETHICAL JUDGMENT

The more attention we pay to how we think about ethics, the more we can think critically about our own ethical reasoning, judgment, language, and the justifications we use. As we work to understand patterns of ethical thinking that ease us off course, we discover we are thinking more clearly and gaining the skill to pull ourselves back from common missteps. As psychologist and Nobel Prize for Economics recipient Daniel Kahneman (2011) put it: “The proof that you truly understand a pattern of behavior is that you know how to reverse it” (p. 133). This is the second of four chapters focusing on various facets of critical thinking: reasoning, judgment, language, and justifications. The previous chapter discussed common errors in ethical reasoning, in this chapter we turn our attention to common pitfalls in ethical judgment.

Ethics requires that we consider options and make a judgment. In our professional capacities we often confront ethical challenges that are rarely simple, obvious, and easy. Subtle ethical issues slip by unnoticed. Ethical crises appear in a clash of competing needs, expectations, and values. Scarce time and resources narrow our options. Personal and professional limits of our training restrict our choices. For all of these reasons, no one can effectively apply the principles in the ethics code or other sources of guidance to real-life situations in an automatic, unthinking, or rote manner. There is no paint-by-numbers approach that works. This chapter explores 12 factors that can draw our ethical judgment off track:

- Cognitive Commitments
- Authorities
- Groups

- WYSIATI
- Imaginative Illusions
- Hindsight Bias
- Correspondence Bias
- False Consensus
- Status Quo Bias
- Optimistic Bias
- Narrative Bias
- Equality Bias

## COGNITIVE COMMITMENTS

New theories, methods, or intervention that challenge dogma, people in power, or “the way we’ve always done it” can run into resistance, ridicule, and minds shut tight. Barbara McClintock knew what that was like. A distinguished scientist, she discovered genetic transposition (“jumping genes”), a stunning advance that earned her dismissive ridicule and ostracism from colleagues for two decades.

When others finally caught up with her and began to grasp the brilliance of her discovery, she described what she had lived through at the banquet when she accepted the 1983 Nobel Prize for Physiology or Medicine:

[My work] revealed a genetic phenomenon that was totally at odds with the dogma of the times, the mid-nineteen forties. Recently, with the general acceptance of this phenomenon, I have been asked...just how I felt during the long period when my work was ignored, dismissed, or aroused frustration .... [My theory] was much too radical for the time .... [During those years] I was not invited to give lectures or seminars, except on rare occasions, or to serve on committees or panels, or to perform other scientists’ duties (“Barbara McClintock—Banquet Speech,” 1983).

History furnishes all too many examples of those labeled lightweights, fools, fanatics, true-believers, pseudoscientists, quacks,

frauds, or heretics: Galileo Galilei, Muhammad ibn Zakariya Rizi, Ruth Sager, Ignaz Semmelweis, to name but a few (for additional information and examples, see Hajdu, 2007; Kohlstedt, 2004; Reynolds, 2004; Solon, 2012). We admire these brave souls. We see what their commitment to an unpopular idea has cost them. Their unwavering loyalty to what they believe to be true, their persistence in looking for evidence to support their vision, and their determination to hold onto their belief despite the resistance it arouses truly inspire us.

A commitment to an approach, theory, or idea can throw our judgment off course in two major ways: (a) by falling prey to either the logical mistake of affirming the consequent; or (b) the inferential mistake of confirmation bias.

The logical fallacy of affirming the consequence, which was discussed in the prior chapter, invites us to assume that *because* our idea evokes resistance, ridicule, or refutation, *therefore* we must be on the right track. Then we come up with reasons for the opposition: Our idea is too radical for those rooted in the status quo, too brilliant for our contemporaries, too threatening to those in power. Carl Sagan defused this kind of fallacy and states: “The fact that some geniuses were laughed at does not imply that all who are laughed at are geniuses .... They laughed at Fulton, they laughed at the Wright brothers. But they also laughed at Bozo the Clown” (1979, p. 64).

For a good description of the biased judgment that can be caused by cognitive commitment, we turn first to Francis Bacon, who in 1620 wrote:

The human understanding when it has once adopted an opinion ... draws all things else to support and agree with it. And though there be a greater number and weight of instances to be found on the other side, yet these it either neglects or despises, or else by some distinction sets aside and rejects .... This mischief insinuate[s] itself into philosophy and the sciences; in which the first conclusion colors and brings into conformity with itself all that come after (1955, p. 472).

Evans (1989) noted that “confirmation bias is perhaps the best known and most widely accepted notion of inferential error.” The

notion “is that human beings have a fundamental tendency to seek information consistent with their current beliefs, theories or hypotheses and to avoid the collection of potentially falsifying evidence” (p. 41).

Cognitive and social psychology have explored how this influence takes different forms. Kurt Lewin (1976; see also Gold, 1999), examined how committing to a decision often seems to freeze the mind, hardening it against reconsideration. Ellen Langer (1989), summarizing the research she and her colleagues had conducted (e.g., Chanowitz & Langer, 1981), described the common process of forming a mindset when we first encounter something and then clinging to it when we reencounter that same thing. Because such mindsets form before we do much reflection, we call them premature cognitive commitments .... The mindless individual is committed to one predetermined use of the information, and other possible uses are not explored (p. 22).

Leon Festinger’s experiments focused on how commitment to an approach, theory, or idea leads to a screening out of any information that would lead to cognitive dissonance. The commitment means that there would be “less emphasis on objectivity and there is more partiality and bias in the way in which the person views and evaluates the alternatives” (1964, p. 155; see also de Vries et al., 2014; Frey & Schulz-Hardt, 2001; Guazzini et al., 2015; Harmon-Jones, 2019; Hill et al., 2008; Morvan & O’Connor, 2017; Munro & Stansbury, 2009; Stice et al., 2015; Tschan, Semmer, & Gurtner, 2009).

Our vulnerability to this bias creates a responsibility to question our own views, whether snap judgments or long-held beliefs. We can balance our loyalty to our judgments if we search relentlessly for facts that do not fit, listen openly to those who disagree, and constantly ask ourselves what the other possibilities are. Otherwise we can end up clinging so tightly to our ethical certainties that we do not notice contradictory information, better possibilities, and the consequences of our own missteps. Once again, Carl Sagan (1991) offers sound advice, recommending:

an exquisite balance between ... skeptical scrutiny of all hypotheses that are served up to us and ... great openness to new ideas .... If you are only skeptical, then no new ideas make it through to you .... If you are open to the point of gullibility and have not an ounce of skeptical sense ..., then you cannot distinguish the useful ideas from the worthless ones (p. 4–5).

## AUTHORITIES

When puzzling over an ethical dilemma, we often turn to authorities. The law, a supervisor, consultation, and the ethics code can provide invaluable help. We misuse these resources, however, if we use them to short-circuit our ethical judgment. As emphasized in [Chapter 1](#), we cannot avoid an ethical struggle by focusing only on the law and claiming “It violates no law [or the law requires it] so it must be ethical.” We cannot shrug off ethical responsibility by explaining that we were just following what our supervisor told us to do. We cannot hide behind ethics codes or the opinion of a supervisor as refuge from an active, creative search for the most ethical response. Although authorities play countless constructive roles in our society, the psychological literature—not to mention history itself—shows the dangers of over-reliance on and unquestioning obedience to authority (see, for example, Darley, 1995; Ent & Baumeister, 2014, 2015; Grzyb et al., 2018; Haslam et al., 2014; Meeus & Raaijmakers, 1986, 1995; Staub, 2014). We are ultimately responsible for our choices with ethical dilemmas.

Awareness of ethics codes, laws, and professional guidelines is crucial to competence in the area of ethics. These documents guide and inform our ethical consideration. They do not take the place of our thoughtful consideration. We cannot apply them effectively in a rote, thoughtless manner. Each new client, whatever similarities to previous clients they may have, is a unique individual. Each situation also is unique and is likely to change significantly over time. Authoritative documents may prohibit some acts as clearly unethical. They may call our attention to ethical concerns in different areas of practice, but they cannot tell us how these concerns will manifest themselves in a particular clinical situation. They may set forth essential tasks that we must fulfill, but they cannot tell us how we

can accomplish these tasks with a unique client facing unique problems. We cannot hide from these struggles.

## GROUPS

Like authorities, groups are a valuable resource. They can provide support, diverse views, the opportunity to work together on an ethical dilemma, and relief from the sense of isolation. But—like authorities—certain group processes can work to block sound ethical judgment. We get ourselves into trouble when we allow groups to shield us from ethical struggles and the sense of ethical responsibility.

Psychologist Paul Meehl (1977) wrote a fascinating essay we recommend to all of this book's readers, "Why I Do Not Attend Case Conferences." He pointed out the "groupthink process" (p. 228) that discourages sound judgment and may be familiar to all of us:

In one respect the clinical case conference is no different from other academic group phenomena such as committee meetings, in that many intelligent, educated, sane, rational persons seem to undergo a kind of intellectual deterioration when they gather around a table in one room (p. 227).

Psychologist Irving Janis (1972) studied ways in which groupthink clouds our judgment. Janis and Mann (1977, pp. 130–131) identified the eight symptoms of groupthink, adapted next, to emphasize their effects on ethical judgment:

1. An illusion of invulnerability, shared by most or all members, which creates excessive optimism and encourages taking extreme risks.
2. Collective efforts to rationalize in order to discount warnings.
3. An unquestioned belief in the group's inherent high ethics, leading members to underestimate their ethical responsibilities or the negative consequences of their behavior.
4. Stereotyped views of those who disagree about ethical issues, encouraging group members to disparage the motives,

intelligence, heart, or good faith of those who disagree with the group's views.

5. Pressure on any group member who dissents or raises serious questions about the group's views or behavior.
6. Self-stifling of deviations from the group's approach; an inclination of each member to deny, discount, or minimize doubts or counterarguments.
7. The illusion of virtual unanimity created by self-stifling and assuming that silence means consent.
8. Some members taking on the role of "mindguard[s]"—members who protect the group from adverse information that might shatter their shared complacency about the effectiveness and morality of their decisions."

In addition, we tend to form groups in a we/they dichotomy, which leads to a subconscious (and sometimes conscious) automatic categorization of people in our "in-groups," those with whom we identify, and our "out-groups," those whom we see as being outside our realm of identification. People in our in-groups are more highly valued, more trusted, and engender greater cooperation as opposed to competition. We have more compassion for those in our in-group than those in our out-group and are more likely to endorse and support those in this category. On the other hand, people in our out-groups are implicitly conceptualized as "they." We often tend to treat out-group members in negative ways (Cikara et al., 2014; Dovidio & Gaertner, 2010; Gilead & Liberman, 2014; Ito, 2013; Opatow, 1990, 1995, 2005, 2012; Sue et al., 2019).

These in group/out group dynamics can have unfortunate effects on the way we "welcome" and provide psychological services to members we've placed in the outgroup category. They also affect how we behave toward our colleagues and new ideas that might lead us to change our mind, even when in- and out-groups are defined by disagreements over ideas. Psychologist Steven Pinker (2006) wrote:



People have a nasty habit of clustering in coalitions, professing certain beliefs as badges of their commitment to the coalition and treating rival coalitions as intellectually unfit and morally depraved. Debates between members of the coalitions can make things even worse, because when the other side fails to capitulate to one's devastating arguments, it only proves they are immune to reason .... New ideas, nuanced ideas, hybrid ideas—and sometimes dangerous ideas—often have trouble getting a hearing against these group-bonding convictions (xxvi–xxvii).

## WYSIATI

In his foreword to the second edition of *What therapists don't talk about and why: Understanding taboos that hurt us and our clients* (Pope, Sonne, & Greene, 2006), former American Psychological Association president Gerry Koocher tells of a fascinating public confession he sometimes makes:

On occasion, I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26 year-old woman together in a quiet darkened room. That disclosure usually elicits more than a few gasps and grimaces. When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll (2006, p. xxii).

It is easy to understand why most listeners are both shocked and critical. A prominent ethicist and former APA president is describing what seems clearly to be his mishandling of a sexualized relationship with a patient. But he is not really making a confession. He's illustrating how easily we make false judgments under uncertainty when we do not know the whole story but assume that we do.

Gerry fills in some of the missing information:

Then I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked how I might help her. She grabbed my hand and said, “Don’t let go.” When the time came for another appointment, I called a nurse to take my place (p. xxii).

The missing facts lead us to very different judgments about the clinician’s behavior and what is actually going on in that quiet, darkened room.

As therapists, we are constantly called on to make judgments without access to complete information. We can’t duck our responsibility to step up and provide knowledgeable and competent help, especially in emergencies. We do the best we can, knowing that in some situations we cannot know all the relevant information. The critical misjudgment springs up when we lose awareness that we do not have all the facts.

Daniel Kahneman (2011) described this mistake as belief in WYSIATI: *What You See Is All There Is*. We all face this hazard as we make judgments under uncertainty and time pressures based on sometimes necessarily incomplete information. Confirmation bias can harden our WYSIATI misjudgments into confidently held certainties that find their way into patient charts, treatment plans, disability evaluations, pre-employment assessments, and courtroom testimony and legal opinions. These certainties screen out or reshape everything the patient says or does that does not fit the misjudgment.

Our judgment that a colleague’s behavior violates ethical standards might change if we did not assume that WYSIATI. We might revise our WYSIATI interpretation of an IQ score and report of psychological assessment involving standardized instruments if we knew that the man had forgotten to take his meds or bring his glasses, that a woman had been threatened by an abusive partner the night before and was afraid he’d show up when she left the assessment, or that a child had been up all night because his parents were fighting and he’d had no breakfast before the testing—but the person conducting the assessment had not been aware of these factors, had neglected to ask, and had not mentioned any of them in

the assessment report. Perhaps we remember doing things that might seem highly questionable, wrong, or outrageous to others if they did not know the whole story.

## **HINDSIGHT BIAS**

Also known as “Monday morning quarterbacking” or “I knew it all along,” hindsight bias is our tendency to imagine, once we know how an event turned out, that we would have much better predictions than we actually would have had we not known the outcome (Arkes et al., 1988; Fischhoff, 1975; Fischhoff & Beyth, 1975; Wood, 1978). Perhaps we are members of a hospital peer review committee, an ethics committee, or an expert witness considering a colleague’s choice when faced with an ethical dilemma. If we know that the choice ended in disaster, we might imagine that we ourselves would’ve chosen more wisely another course had we faced the same dilemma. Imagining that the colleague lacks the sound judgment that we would’ve used in that situation may have unfortunate consequences for judging our poor colleague’s choice.

## **CORRESPONDENCE BIAS**

Also called the fundamental attribution error (Ross, 1977), correspondence bias leads us to downplay or ignore entirely situational influences when judging someone else’s behavior, imagining the behavior to be caused by the individual’s personality, attitudes, or character, while often attributing our own less-than-admirable behaviors to the situation, a bias that tends to be more prevalent in western countries (Bauman & Skitka, 2010; Blanchard-Fields et al., 2007; Jones, 1979; Ross & Nisbett, 2011). We cut an ethical corner because we were under a lot of pressure, in a hurry, or sleep-deprived; other people do the same thing because they are dishonest, basically unethical, or lack integrity.

## **FALSE CONSENSUS**

Also called egocentric bias, false consensus bias is our tendency to imagine that other people are more like us than they really are, and

that our behaviors are more appropriate and more common than alternate behaviors (Mullen et al., 1985; Ross et al., 1977; Windschitl et al., 2013). Our vulnerability to this bias underscores the importance of checking carefully with patients during the informed consent process to make sure we are not assuming that they share our assumptions, our values, and our preferences. The false consensus bias highlights the importance of consultation to strengthen our awareness of how our imagination is leading us toward biased judgments. This bias shows how “everybody does it” and similar spins on ethically questionable decisions deserve careful scrutiny.

## **STATUS QUO BIAS**

A bias toward the status quo often tends to run through our judgments and decision-making (Kahneman et al., 1991; Nebel, 2015; Proudfoot & Kay, 2014). This bias makes it hard for us to give weight to ethical choices that will force major changes in our lives or in the systems we are a part of, and once we make such a choice, we would have follow through on it. Familiarity, habits, a resistance to change, and “the way we’ve always done it” can, under some circumstances, be powerful enemies of clear thinking. This tendency to stick with the way things are now may join forces with related common tendency in making judgments and decisions: omission bias.

## **OMISSION BIAS**

If two of our options cause equally terrible outcomes and if one involves doing something and the other involves doing nothing, we tend to gravitate toward the one that involves inaction and view ourselves as less responsible for the terrible outcome (Chung et al., 2014; Spranca et al., 1991). Sins of omission often seem less culpable than sins of commission, even when they lead to identical outcomes. In our imagination, the active doing of something seems more causally related to the bad outcome than our doing nothing whatsoever.

## OPTIMISTIC BIAS

Daniel Kahneman (2011) wrote that “in terms of its consequences for decisions, the optimistic bias may well be the most significant of the cognitive biases” (p. 255). We have a tendency to believe that our decisions carry less risk than they actually do, that our judgments and decisions are more likely to be born out than which is justified, that options and opportunities are more favorable than an objective assessment warrants. When we fall prey to the *planning fallacy*, a result of optimistic bias, we imagine that we will accomplish our plans more easily, more quickly, more successfully than they will likely work out. Of course, that is if they *do* work out. Optimistic bias makes it hard to imagine that we will meet any obstacles, encounter delays, get distracted, or tire out. Remember, we plan and then life happens.

## NARRATIVE BIAS

Narrative bias leads us to construct or believe narratives that explain why events happen by oversimplifying and over-interpreting. Nassim Taleb (2010) writes:

The narrative fallacy addresses our limited ability to look at sequences of facts without weaving an explanation into them, or, equivalently, forcing a logical link, an *arrow of relationship*, upon them. Explanations bind facts together. They make them all the more easily remembered; they help them *make more sense*. Where this propensity can go wrong is when it increases our *impression* of understanding (p. 43; italics in original).

Many other factors such as anchoring, availability, halo effects, outcome bias, past experience, and representativeness, to name but a few, can of course distort our ethical judgment and decision-making. We recommend Bushyhead and Christensen-Szalanski (1981); Connolly et al. (2000); Gilovich et al. (2002); Kahneman (2011); Kahneman and Klein (2009); Kane and Webster (2013); Rosenzweig (2014); Taleb, 2010; Taleb and Blyth (2011); and Tversky and Kahneman (1974) as wonderful resources for those wishing to learn more in this area.

## EQUALITY BIAS

We live and develop in social systems that are organized by institutions, laws, and policies that result in the unequal distribution of resources, rights, and responsibilities (Cook & Hegtvedt, 1983). Such unequal distribution produces different costs and burdens among society's constituents. However, we are socialized to believe that the right thing to do is to make decisions based on the principle of equality—and that this alone prevents the unequal distribution of resources (Lamont & Favor, 2017). While equality is important, it is insufficient. Equality assumes an equal playing field, does not consider power, and fails to capture the various realities that affect individuals within a society. One way to strengthen our ethical decision-making process, and not fall prey to the equality bias, is to consider using the principle of equity which “is grounded in the equity theory, which is a positive theory pertaining to individual conceptions of fairness” (Espinoza, 2008, p. 348). To illustrate, many therapists have a policy where they charge all clients for a full session when clients fail to cancel their appointment 24 hours before it was originally scheduled. An equality bias will drive the therapist to charge everyone for the session without considering pros and cons, any treatment implications, and the unique circumstances impacting the client.

We can strengthen our ethical decision-making if we remain aware of these factors and how they can sometimes serve us well, but other times sweep us off course in our inferences. Having discussed common problems in ethical reasoning and in ethical judgments, we turn in the next chapter to common problems in ethics and language.

# Chapter 13

## LANGUAGE AND ETHICS

Language shapes the way we experience the world. Words matter, they have power, and what we call things has implications. Critical thinking and ethics require that we pay attention to the words and the labels we use to describe, communicate, and think. A friend may dampen our day by telling us about a despicable unethical psychologist, a law breaker who had robbed a defendant of his right to a fair trial and showed no remorse. Another friend lifts our hearts by mentioning a psychologist who is so committed to her ethical values that she went to extraordinary lengths to “do no harm” to her client, even at great cost to herself. We then realize that both friends are describing the same psychologist: A therapist who refused a court order—even though it meant spending time in jail and a suspension of her psychology license—to provide her therapy records to a lawyer representing the client’s husband in a criminal trial. The husband had threatened to kill the client and her children and the records contained information that could allow the husband to piece together enough information to discover where the client and her children lived, the identities of mutual friends who had helped the woman escape to a place of refuge, the names of those who were providing the woman and her children with food and other resources until they could start a new life, and so on. As Rhoda Unger (1983) reminds us: “Description is always from someone’s point of view and hence is always evaluative” (p. 140).

Consider the following scenario. An executive director hesitates to fire therapists who helped found a clinic and stayed loyal, at considerable personal sacrifice, through the lean years. Can she push these colleagues out the door and cut off their income just to make more money by hiring less qualified therapists for lower pay? That might be hard, at least from a public relations perspective even if she has no conscience. She finds it easier when she throws a word blanket over what she does and the people she does it to. She can use

language to block our view. She casts aside words like “firing” and “colleagues” along with the names of the people who will vanish from the scene. Office memos mention a “multitude of unfortunate but inescapable factors necessitate a data-driven paradigm shift and substantial but temporary reduction in force in order to maximize competitive preparedness and responsiveness in an unpredictable and volatile marketplace.” Press releases hail an “innovative and state-of-the-art intervention and cutting-edge development strategy of providing maximum direction, safety, and assistance activity during the discrete transitional carefully-calibrated process steps associated with the temporary downsizing implementation phase and the arrangement of management-directed outplacement services.” This means the company has hired armed guards to escort each therapist out of the building, help carry any belongings, and make sure the therapists do not re-enter the building. What are some of the thoughts and reactions you are having to this scenario? Do you see the relevance and power of the words used?

In the above scenario, as in many others, the descriptions provided obscure what the executive director is doing and the people she is doing it to. Language can deceive by design. It conceals, misdirects, and creates the verbal equivalent of optical illusions or impenetrable fog. But even when used with the best of intentions, careless or bloated language makes it hard to think clearly. Many of us have gone missing in journal articles, last seen slogging our way through paragraphs packed with professional jargon, clichés, and words that are not-quite-right but loaded with lots of syllables.

In his classic essay, “Politics and the English Language,” George Orwell (1946) rewrote a widely quoted biblical passage in what he called “modern English.” Here’s the original passage from Ecclesiastes in the King James Bible:

I returned and saw under the sun, that the race is not to the swift, nor the battle to the strong, neither yet bread to the wise, nor yet riches to men of understanding, nor yet favor to men of skill; but time and chance happeneth to them all.

See if Orwell’s translation reminds you of any professional articles, lectures, or discussions: “Objective consideration of contemporary phenomena compels the conclusion that success or failure in



competitive activities exhibits no tendency to be commensurate with innate capacity, but that a considerable element of the unpredictable must invariably be taken into account” (p. 163).

Too often we lose sight of ethical issues as they disappear in clouds of clichés, jargon, deceptive words, and careless language. Reading more carefully strengthens, deepens, and informs our ethical awareness, helping us to notice when words point our attention toward small details and rush us along, hoping we won’t see the big picture. We read more thoughtfully, less passively, noticing when words push us to assume, accept, and conclude instead of stopping to question and consider.

This section looks at common language patterns that hide or confuse ethical issues, responsibilities, and consequences. We present the patterns in extreme form that makes them easier to recognize and remember. If we learn these basic patterns in simplified form, they are easier to spot when they try to sneak by us in the busy rush of our day-to-day work.

Most of us will remember seeing these patterns in the newspaper, on television, on our computer screens, our phones, and during our professional meetings. What is much harder—but more useful—is to try to remember when we ourselves have fallen into these patterns.

Orwell emphasized how universal and persistent these word tricks are. He notes that they “are a continuous temptation, a packet of aspirin always at one’s elbow. Look back through this essay, and for certain you will find that I have again and again committed the very faults I am protesting against” (1946, p. 168).

We start with Jack, our hypothetical therapist, who did something unethical, was caught and disciplined, knows what he did was wrong, is sorry, and wants to make a public statement to take responsibility and apologize.

Here is what Jack did: He stole therapy records of the clinic’s famous clients, altered them to make it look as if the clients had described lurid sexual activity to their therapists, and then sold the records to tabloids.

Jack calls a Zoom news conference and says:

I stole the patient files, added some lies to them, and sold them. I have no excuses or explanations. I am solely responsible. I knew it was wrong and would hurt innocent people who trusted the clinic, and I did it anyway because I wanted the money. I apologize to everyone, especially to those whom I've hurt. I will do whatever I can to try to make things right.

Here are some alternate statements that show common language patterns that can interfere with clear thinking about ethics. As in the prior section on logical fallacies, there is a brief description and example of each pattern.

## **SUBSTITUTE THE GENERAL FOR THE SPECIFIC**

In this pattern, both the specific person and the specific act disappear. A description of a general category of acts and a vague reference in the third person replace (and hide) the specifics. Jack might say: "I believe that everyone knows that taking a patient's file without the patient's permission and using it for some purpose for which it was not intended is wrong. Anyone who does something like that is out of line."

## **USE A CONDITIONAL FRAME FOR CONSEQUENCES**

The speaker shifts the focus to the question of whether the acts affected anyone. The apology is made contingent on how others reacted or were affected. Example: "If my actions harmed, or even just offended, anyone—and I can well understand how that could happen—I apologize."

## **USE DENIED MOTIVATION AS MISDIRECTION**

Instead of honestly stating the motivation, the speaker seeks self-exoneration by talking about what the motivation was not. Denying an irrelevant charge that no one has made can be an effective rhetorical tactic. The denials are often true. For example, the person who repeatedly embezzles pension funds, uses substandard materials

to build high-rises, speeds while drunk, and stresses that they never meant to hurt anyone was probably not acting with the intention of making other people suffer. Example: “I can honestly say that at no time during these unfortunate events with the clinic records did I ever intend for anyone to be hurt.”

## **USE THE ABSTRACT LANGUAGE OF TECHNICALITIES**

The speaker translates people and events into abstractions, using the jargon of technicalities. Jack could say:

I know that many of you have heard rumors and you deserve to know what happened. I want to acknowledge publicly, in closing this unfortunate chapter, that I did not fulfill all requirements in the JCAHO [Joint Commission on Accreditation of Healthcare Organizations] manual for the handling of charts. There were instances in which I reviewed and added information without following all the bureaucratic specifications for identifying the source of additional material, and I did not always follow the precise procedures for obtaining informed consent for release of information in transferring these charts to individuals who lacked proper authorization to receive them. I regret my lack of attention to JCAHO and similar regulations, and I assure everyone that I will be reviewing those regulatory specifications and will make every attempt to conform to those guidelines in the future.

## **USE THE PASSIVE VOICE**

The speaker disappears. Things are done without reference to who does them. Jack would say:

I know that all of you, like me, want to know the results of the extensive, no-holds-barred investigation that was conducted by my secretary in the light of recent allegations. I have been authorized to provide you with a complete report of the findings. Regrettably, the investigation confirmed that some files were taken without authorization, were altered, and were provided to those who should not have received them. Both the policies of our own clinic and the regulations of external authorities were violated. We wish to assure everyone that appropriate actions will be taken so that the problems will be addressed. Relevant steps have already been taken toward remedying this situation.

## **MAKE UNIMPORTANT BY DESCRIBING WHAT DID NOT OCCUR**

The speaker anchors the presentation in scenarios of extreme consequences that did not occur. The contrast makes whatever may have happened seem trivial. Here is Jack's statement:

All of us have been concerned about the effects of recent events. As you know, allegations led to thorough investigations by several agencies. These investigations are now concluded. Let me assure you that regardless of what you may have heard, no patient died or even suffered any physical injury whatsoever, whether chronic or acute, significant or trivial. I believe that some of you have been concerned that some of the patients might, as a result of these events, become distraught and take their own lives. However, I want to assure each and every one of you that no patient has committed suicide or, to the best of our knowledge, threatened or attempted suicide. As a final note, I believe that some of you were distressed that the events may have involved serious criminal behavior of the kind exemplified by what our state terms a Class A felony. However—and I want to emphasize this!—not only were there no charges of Class A felonies for anyone involved in this sequence of events, but no one from the district attorney's office ever mentioned to me even the remote possibility of such charges. Although I think any of us might acknowledge that perhaps things might have been handled a bit better, it is important—and an issue of fundamental fairness—to keep what happened in perspective, to avoid the witch hunt mentality, and to remember that none of us is perfect. Thank you for your time and attention.

## **REPLACE INTENTIONAL UNETHICAL BEHAVIOR WITH THE LANGUAGE OF ACCIDENTS, MISFORTUNE, AND MISTAKES**

The speaker fails to mention making a conscious decision to profit by stealing charts, filling them with lies, and selling them to the highest bidder. The description makes the speaker a victim of being an imperfect human, of lacking omniscience and infallibility. The speaker pushes the acts into the category of those random, inevitable mistakes that afflict us all and are beyond our control. At worst, they are a matter of having fumbled a matter of judgment, although, if this construction is examined closely, it seems to assume that almost anyone would have difficulty judging whether stealing charts, inserting bogus material that will hurt patients, and selling them is

ethical. This may not be quite as hard a judgment as the rhetoric implies. Here is how Jack would use that tactic:

I wanted to address the unfortunate events that have troubled us all lately, so that you would understand what occurred and why. To my great regret, I have realized now in hindsight—hindsight being 20-20—that in handling clinic records, I made some mistakes. I'm sure you all know how I feel about this, and I hope you will be understanding and chalk this unfortunate error in judgment up to youthful indiscretion, my tendency to want to take on a little too much so that this clinic will function as well as possible, and to a momentary lapse of attention in the crush of daily demands that I face as clinic director. All of us make mistakes in our work here, and I want you to know how sorry I am for this accidental misstep.

## **SMOTHER THE EVENTS IN THE LANGUAGE OF ATTACK**

Assuming that the best defense is a good offense, the speaker avoids responsibility by attacking others. Whatever the speaker may have done becomes trivial or justifiable in light of the terrible things other people have done. The language of attack stirs up emotional responses. It works against people joining together to examine the facts and their implications and sets people against each other, dividing them into “us” (the good people, unjustly attacked) and “them” (the bad people, who deserve what we can dish out). The speaker’s rhetoric serves to draw listeners into his or her camp and to ridicule or intimidate those who are on the other side (i.e., the enemy). The rhetoric encourages listeners to evaluate claims not in terms of whether they are valid and relevant but in terms of whether they support the listener’s loyalty to one side.

Jack comes out swinging:

Thank you for coming today. I will take just a few minutes of your time with the following statement about the recent events in which I have had to endure the most vicious attacks. It is a sad sign of our “take no responsibility” culture that several patients who came to our clinic in need and were not turned away have shown their gratitude for all we have done for them by trying to gain publicity for themselves—their 15 minutes of fame—and to enrich themselves at our expense by filing formal complaints. This is one of the most destructive aspects of the modern mind-set: it’s all me-me-me, without thinking of how such complaints might affect the rest of us who have dedicated our lives to healing the sick, comforting those in need, and helping those who turn to us in their hour of crisis. The selfishness of such formal complaints is hard to comprehend. These scurrilous complaints rob us of the time and resources that we would otherwise use to provide services to those who have nowhere else to turn. And it is for those people who have so little and suffer so much that this clinic has resolved to fight these complaints with every resource we can muster. We have hired some of the most skilled and successful attorneys that this nation has yet produced, and they have already filed countercharges in civil court. The support staff aiding these attorneys have discovered, in the course of their extensive background research, some facts about those individuals—and the families of those individuals—who filed complaints against us that I believe will surprise the public and place these vicious complaints in their proper perspective. I’ve been asked by our attorneys not to reveal that material at this time, but I assure you that our attorneys will present it at the proper time—in court—should these complaints go to trial. Again, pursuant to the advice of our attorneys, I will have no more comment on this matter at this time. Thank you for your time and attention.

## **USING LANGUAGE TO GENERATE EMPATHY**

The speaker may also center themselves and use language to gain empathy from others. Here is how Jack may motivate others to put themselves in his shoes:

As you all know, I am the most caring, loving, and compassionate therapist you will ever meet. I have always demonstrated the utmost respect for my work and conducted myself in a responsible manner. Unfortunately, over the last year, my life has taken a downturn. I went from having a family, a loving partner, and a home full of joy to losing it all in an instant. My partner, the person to whom I gave my entire life betrayed me, my children went to live with her, and I lost the place where we lived for over 20 years. I am so hurt right now. I know, you will find it in your heart to have me in your thoughts and prayers. And so, I ask that you please think about what I am going through and how difficult this whole thing has been for me.



# Chapter 14

## ETHICS PLACEBOS, RATIONALIZATIONS, AND EXCUSES

*Ethics placebos* (Pope, 2015b, 2017) are what we all tend to reach for when we need fast, effective relief from the heartburn of an upsetting ethical challenge. Part of us *wants* to do the right thing. But another path looks so much safer, easier, simpler, quicker, more popular, more profitable, or more fun. Ethics placebos switch the process from finding and taking the most ethical path to finding ways to justify what we *want* to do.

Sometimes we may reach for industrial-strength ethics placebos, but usually we can find a way to do what we want to do by turning down the volume on our conscience and dulling our ethical awareness. The most common ethics placebos can spin the most shady behaviors into seemingly ethical ideals while giving us an excuse to indulge in unethical or at least questionable behavior. Nonetheless, it is important to constantly remind ourselves of the responsibility and trust that communities, individuals, and the public have put in us. In return, we have a responsibility to do what is best for our clients and not just what is easier, simpler, more popular, or what fits our personal needs, schedule, and individual preferences.

We restate a major theme of this book: We believe that the overwhelming majority of psychologists are conscientious, caring and responsible people who are committed to ethical behavior. However, we also know that none of us is infallible and that all of us, at one time or another, have been tempted to reach for at least a few of these ethics placebos and might be able extend the list of brands.

In this chapter we provide you with a list of 30 excuses that clinicians may make to justify unethical behavior. Many of the false

justifications which we present below, appeared in previous editions of this book, and some were added when the list appeared in the volume, *What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients* (Pope, Sonne et al., 2006).

1. It's not unethical as long as a hospital administrator or insurance case reviewer required or suggested it.
2. It's not unethical if the professional association you belong to allows it.
3. It's not unethical if an ethics code never mentions it.
4. It's not unethical as long as it's not illegal.
5. It's not unethical if we can use the passive voice and look ahead. If someone discovers that our curriculum vitae (CV) is full of degrees we never earned, positions we never held, and awards we never received, all we need to do is say that mistakes were made, they were in the past, and it's time to move on.
6. It's not unethical as long as we can name others who do the same thing.
7. It's not unethical since no one else is perfect. Hey, everyone makes mistakes! So I'm sorry I borrowed your laptop with all your dissertation data and clinical notes on it and it got stolen out of my car, but it could happen to anyone, no one's perfect, so don't make a big deal out of it. Just file a claim with your insurance company and, hey, you'll even get a new one! Wouldn't that be great! Want to get a brewski?
8. It's not unethical as long as we didn't intend to hurt anyone.
9. It's not unethical even if we hurt someone as long as the person we harmed had it coming, provoked us, deserved it, was really asking for it, or practically forced us to do it—or, failing that, has not behaved perfectly, is in some way unlikable, or is acting unreasonably.
10. It's not unethical as long as there is no body of universally accepted, methodologically perfect (i.e., without any flaws, weaknesses, or limitations) studies proving—without doubt—that

exactly what we did was the necessary and sufficient proximate cause of harm to the client and that the client would otherwise be free of all physical and psychological problems, difficulties, weaknesses, or challenges. This view was succinctly stated by a member of the Texas pesticide regulatory board charged with protecting Texas citizens against undue risks from pesticides. In discussing Chlordane, a chemical used to kill termites, one member said, “Sure, it’s going to kill a lot of people, but they may be dying of something else anyway” (“Perspectives,” 1990, p. 17).

11. It’s not unethical if we could not (or did not) anticipate the unintended consequences of our acts.
12. It is not unethical as long as my behavior is consistent with my personal values.
13. It is not unethical as long as my client consented to it, or requested it...
14. It’s not unethical if we see it in the context of everything the person ever did—in which case, it is only a drop in the bucket. For example, it may seem as if a therapist who has submitted hundreds of thousands of dollars’ worth of bogus insurance claims for patients he never saw might have behaved “unethically.” However, as attorneys and others representing such professionals often point out: It was completely inconsistent with the high ethics manifest in every other part of the person’s life (that we know about), and insignificant in the context of the unbelievable good that this person has done and continues to do.
15. It is not unethical as long as I can describe how what I did is consistent with my theoretical orientation.
16. It’s not unethical if we can say any of the following about it (feel free to extend the list):
  - a. “What else could I do?”
  - b. “Anyone else would’ve done the same thing.”
  - c. “It came from the heart.”
  - d. “I listened to my soul.”
  - e. “I went with my gut.”

- f. "It was the smart thing to do."
  - g. "It was just plain common sense."
  - h. "I just knew that's what the client needed."
  - i. "Look, I was just stuck between a rock and a hard place."
  - j. "I'd do the same thing again if I had it to do over."
  - k. "It worked before."
  - l. "What's the big deal?"
  - m. "Come on, no one was really hurt."
  - n. "I meant well."
17. It's not unethical if we are known as experts in the area and have written an article, chapter, or book about it.
  18. It's not unethical as long as we were under a lot of stress. No fair-minded person would hold us accountable when it is clear that it was the stress we were under—along with all those other factors—was the clear cause of what happened.
  19. It's not unethical as long as no one ever complained about it.
  20. It's not unethical as long as we know that the people involved in enforcing standards (e.g., licensing boards or administrative law judges) are dishonest, stupid, destructive, and extremist; are unlike us in some significant way; or are conspiring against us.
  21. It's not unethical as long as we felt under a lot of pressure to do it from our supervisor, the chair of our training program, or someone else in authority.
  22. It's not unethical if we were just following orders.
  23. It's not unethical as long as it results in a higher income or more prestige (i.e., is necessary).
  24. It's not unethical if we're victims. Claiming tragic victim status is easy: We can always use one of two traditional scapegoats: (1) our anything-goes society, which lacks clear standards and leaves us ethically adrift; or, conversely, (2) our coercive, intolerant society, which tyrannizes us with "political correctness," dumbs us down, and controls us like children. Imagine, for example, we

are arrested for speeding while drunk, and the person whose car we hit presses vengeful charges against us. We show ourselves as the real victim by pointing out that some politically correct, self-serving tyrants have hijacked the legal system and unfairly demonized drunk driving. These powerful people of bad character and evil motivation refuse to acknowledge that most speeding while drunk is not only harmless—actuarial studies show that only a small percentage of the instances of drunk speeding actually result in harm to people or property—but also sometimes unavoidable, profoundly ethical, and a social good, getting drivers to their destinations faster and in better spirits. We stress that any studies seeming to show drunk speeding is harmful are not just unscientific (e.g., none randomly assigns drivers to drunk speeding and nondrunk speeding conditions) but hopelessly biased (e.g., focusing on measures of harm but failing to include measures sensitive to the numerous benefits of drunk speeding). This flipping the roles of victim and victimizer can be powerful. Freyd described it as **DARVO: Deny, Attack, and Reverse Victim and Offender**, and she and her colleagues have researched it (see, e.g., Freyd, 1997; Harsey & Freyd, 2020; Harsey et al., 2017). The concept has found its way not only into law review journals (e.g., Cantalupo, 2020) and news articles (e.g., de Morales, 2017) but also popular entertainment (e.g., “It’s Called DARVO—South Park—Season Finale” 2019). Ta-Nehisi Coates (2010) wrote that “the most potent component of racism is frame-flipping—positioning the bigot as the actual victim. So the gay do not simply want to marry, they want to convert our children into sin. The Jews do not merely want to be left in peace, they actually are plotting world take-over. And the Blacks are not actually victims of American power, but beneficiaries of the war against hard-working whites” (para. 5).

25. It’s not unethical as long as there are books, articles, or papers claiming that it is the right thing to do.
26. It’s not unethical to engage in, enable, or passively allow racist behavior to happen as long as we can claim that we ourselves are completely colorblind and that we don’t even notice race and skin color.

27. It's not unethical as long as it would be very, very hard—almost impossible!—to do things another way.
28. It's not unethical as long as we can find a consultant who says it's okay.
29. It's not unethical as long as we can find an attorney who says it's OK.
30. It's not unethical as long as you had too many other things on your mind to think about it.

Remaining mindfully aware of the ways that each of us may be vulnerable—particularly at times of stress or fatigue, of great temptation, or temporary weakness—to these cognitive strategies may be an important aspect of our ability to respond ethically to difficult, complex, constantly evolving situations, particularly at moments when we are not at our best. Reminding ourselves of our own unique patterns of vulnerability—particularly when we are tired, stressed, or distressed—to reach for these handy ethics placebos may help us to resist temptation and keep searching for the most ethical response to our work's complex, constantly changing challenges.

# **Part II**

## **SPECIAL TOPICS**

# Chapter 15

## BEGINNINGS AND ENDINGS, ABSENCE AND ACCESS

You return a phone call from a middle-aged man who is looking to begin therapy. He worries that the company he works for has been struggling and may lay him off. He can't find any other openings in the area and can't stand the thought that he might not be able to support his family. You talk with him for about 10 or 15 minutes getting basic information, including his insurance, and set up an appointment 10 days later, your first opening. Four days later a public defender calls you. The company fired the man, who returned with a gun and shot his supervisor. The public defender is calling you to ask if you would send him your records and talk with her a little about your assessment of the man, who has named you as his therapist. But wait! Did one phone call mean you're the man's therapist? Did your professional responsibilities start when you talked with him, heard why he wanted therapy, asked him for basic information, and decided to schedule a session with him?

...

Your client stops connecting for Zoom sessions. You don't know why. She does not return the phone messages or respond to the letter you sent her. Five weeks have passed. Does this meet the clinical, ethical, and legal standards of "termination" in your jurisdiction? What additional steps, if any, would you take?

...

A fragile client has been making gradual progress in therapy when his partner dies unexpectedly and he becomes suicidal. The same week his insurance company notifies you that the client has reached the limits of coverage and the company will approve no additional sessions.



■ ■ ■

Ethics includes thinking clearly about the boundaries of our work. Where is the boundary marking the start of therapy? What marks the end? Discussing information about the beginning and ending of therapy, as well as about availability of services during therapy, helps our client to provide consent that is truly informed ([Chapter 16](#) provides a more detailed discussion of informed consent).

People who seek our help have a right to know when they become our client as well as when the professional relationship ends. They need to know how available we are, including when and how can they get in touch with us. This chapter discusses some of those issues of beginnings, access, absences, and endings.

## **ACCESSIBILITY FOR PEOPLE WITH DISABILITIES**

Our decisions about how accessible we make our services to people with disabilities reflect our ethical values (Pope, 2005), and they affect many people, both directly and indirectly. About 15% of the world's population—around 1 billion people—experience some form of disability (World Bank, 2020). In the United States, of the 61 million people living with disabilities, 13.7% have serious difficulty with mobility, 10.8% with cognition, 6.8% with independent living, 5.9% with hearing, and 4.6% with vision (Center for Disease Control, 2020). Of the 6.2 million Canadians aged 15 or over who are living with a disability, 37% of the disabilities were mild, 20% moderate, 21% severe, and 22% very severe (Statistics Canada, 2018a). The most common types were related to pain, flexibility, mobility, and mental health. Statistics Canada (2018b), a governmental agency, describes how our understanding of disability has changed:

The concept of disability has evolved over the past three decades, moving from a more medical model to a social one. Initial concepts focused more on physical and sensory impairments as well as the health conditions of an individual. Conversely, the social model of disability has evolved to also include cognitive and mental health-related impairments, in addition to the barriers which may prevent or limit one's full participation in society. It acknowledges that barriers posed by the environment also need to be addressed in order to give everyone an equal chance of participating more fully in society (para. 4).

The following questions are useful in finding out if your practice is accessible to people with disabilities:

- If you have a website, is it accessible to those who have a disability and use assistive technologies such as braille displays, screen readers, screen magnifiers, virtual keyboards, head-pointing-puff-activation, other switch-access systems, etc.? How difficult is it for someone who is blind to navigate your site?
- Would a client who is deaf face needless challenges reaching you?
- What barriers, if any, do people who use wheelchairs, walkers, or other walking aids encounter when they come to the building in which you do therapy and enter your office (Pope & Vasquez, 2005)?
- Would a person who is blind find it easy to navigate your building and find the right room?
- Do you have area rugs, chairs, or furniture that can pose a hazard for people with mobility difficulties?
- Do you have any policies that exclude people with disabilities from receiving services from you (e.g., bringing a service dog)?
- Would a person who uses sign language to communicate be able to receive services from you?

## **CLARIFICATION**

Therapists must be alert to possible complications and confusions. For example, someone new calls for an appointment. The therapist

assumes that the session is an initial evaluation to discuss possible treatment directions (e.g., if therapy makes sense for the individual, or what modality of therapy under what conditions implemented by what clinician seems most promising). The caller, however, assumes that the therapist, by accepting that request for an initial appointment, is now their therapist. Another client, several months into treatment, boils over with rage at the therapist but can't give voice to the anger, bolts from the room halfway through the session, and stays out of touch for the next five weeks, completely unreachable. Is that client still a client, or has termination occurred?

Trying to prevent needless misunderstandings about the beginning and ending of therapy is part of our ethical responsibility. In addition, clarifying availability and access to services are important parts of our ethical duties. Another vital part is to make sure the client understands clearly when and under what circumstances the therapist will be available for video conferencing or in-person sessions, or for telephone or other communication, and what resources will be available for the client when the therapist is not available.

Clarification is important for at least five reasons:

1. It forces the therapist to consider carefully this client's needs for telephone, e-mail, or other access during the course of therapy. For instance, is this an impulsive, depressed client with few friends who might need contact with the therapist or some other form of support in the middle of the night to prevent suicide? Clarification enables the therapist to plan for such contingencies.
2. By leading the therapist to specify backup availability—for example, what clients can do if they are unable to reach the therapist in an emergency—enables the therapist to prepare for therapeutic needs that are difficult or impossible to anticipate. For example, a client with moderate coping resources may attend appointments regularly over the course of a year or two, never contacting the therapist between sessions. However, during a period when the therapist is seriously ill and unavailable, the client may experience multiple losses, such as the loss of a job or the death of a child. The client may become acutely suicidal and need fast access to resources. Careful planning by the therapist

allows them to meet the client's needs that may emerge from unforeseen events which are virtually impossible to anticipate.

3. Clarifying access to the client about other therapeutic resources encourages the therapist to think carefully about how times of access and lack of access may affect clients and the course of treatment. For example, some clients are likely to experience overwhelming feelings of sadness, anger, or abandonment when the therapist goes on vacation. Other clients may find the clear boundaries that the therapist has established so uncomfortable and infuriating that they are constantly testing both the therapist and the boundaries. Such clients may frequently show up at the therapist's office at the wrong time for their appointment, may leave urgently cryptic messages ("Am quitting therapy; no hope; life too painful; can't go on") for the therapist without leaving a number where they can be reached, and may persistently try to discover the therapist's home or e-mail address, home or cell phone telephone numbers, ask to become the therapist's "friend" on Facebook and other social media, and scour the web for information about the therapist and the therapist's family.
4. When therapist and client work together to develop a plan for emergencies during which the therapist might not be immediately available, the process can help the patient to assess their dependence and needs for help and to assume—to the extent that they are able—realistic responsibility for self-care during crises. For example, the therapist may ask the client to locate the nearest hospital providing 24-hour services and develop ways of reaching the hospital in an emergency. As the client assumes responsibility for this phase of crisis planning, they increase their sense of self-efficacy and self-reliance (within a realistic context), become less inclined to view therapy as a passive process (in which the therapist does all the "work"), and may feel less panicky and helpless when facing an impending crisis or the therapist's future absences. In this sense, planning becomes an empowering process for the client.
5. The process of clarification encourages the therapist to consider carefully their own needs for time off, away from the pressing responsibilities of work. Planning helps the therapist avoid

burnout. The drawing of boundaries also encourages the therapist to attend explicitly to other sources of meaning, joy, fulfillment, and support so that they do not begin looking to clients to fill personal needs (see [Chapter 17](#)). This is a crucial aspect of the therapist's maintaining emotional competence (see [Chapter 6](#)).

Setting appropriate, workable, and therapeutic boundaries around availability involves balancing our own personal needs, theoretical orientation, and style of practice with each client's unique clinical needs. Some therapists maintain flexible boundaries in several areas, including time limits. Others hold to exact time boundaries. With virtually no exceptions, they begin and end the session right on the dot. Even if the client has just experienced a painful breakthrough and is in obvious distress, they do not extend the therapy session. In some situations, ending promptly is a practical necessity: The therapist may have another client scheduled to begin a session immediately. In other situations, observing strict time boundaries is required by the theoretical orientation: Running over the time boundary might be considered by the therapist to constitute a breaking of the frame of therapy or represent the therapist and client colluding in acting out.

When we arrive at an approach to time boundaries that best fits our personal needs, our approach to therapy, and the client's clinical needs, we need to make sure that the client understands our policy. Finally, it is also important for therapists to understand and consider how each person (both therapist and client) conceptualize and use time which is heavily influenced by one's culture. For instance, some clients may respond differently to how sessions are timed, when they begin, how they end. It is important to create space early on in the relationship to discuss and communicate this information.

## **THERAPIST AVAILABILITY BETWEEN SESSIONS**

When and under what conditions do we make ourselves available to clients between sessions? Some therapists receive nonemergency calls from clients whenever they are free during reasonable weekday hours. A very few therapists take nonemergency calls when they are

conducting therapy. We recommend against this practice, which seems disrespectful of the client who is in session and seems to have many potentially harmful effects on the course of therapy for the client whose session is interrupted (or is aware that any session might be interrupted at any time by nonemergency calls to the therapist).

The therapist needs to be clear about the times between sessions when they can be contacted on a nonemergency basis. For example, are weekend calls or calls on holidays such as Labor Day, Memorial Day, or Martin Luther King Jr. Day acceptable?

An extremely important point to clarify is whether the therapist will speak with the client more than briefly by telephone when there is no emergency. Some clients like to use telephone calls or e-mail communication to address unresolved issues from the previous therapy session, share a dream while it is still fresh in their mind, or talk over how to handle a situation at work. Some therapists may see such extra communications as therapeutic for some clients. The telephone sessions may, for example, help particularly fragile and needy clients, who might otherwise require day treatment or periodic hospitalizations, to function under the constraints of once- or twice-weekly outpatient therapy. They may help some clients learn how to use and generalize the adaptive skills they are acquiring in office sessions. The extra communications serve as a bridge between office therapy sessions and independent functioning by the client.

Other therapists may prefer to keep the work strictly within the frame of the therapy session. They believe that phone, e-mail, or text communications between sessions are—except under rare emergency conditions—countertherapeutic. For example, they might view extended telephone contacts between sessions as similar in nature and effect to going beyond the temporal boundary at the end of a session. Other therapists may, as part of their own self-care (see [Chapter 17](#)), limit out-of-office contacts to emergencies. Some therapists may suggest that clients journal their thoughts and feelings between sessions and bring those to the next session for possible discussion. Communication of therapeutic content via internet should be considered carefully and used only with adequate safeguards to protect confidentiality.

Again, whether the therapist uses an approach that includes or prohibits discussions with clients between regularly scheduled in-person therapy sessions matters less than that: (a) the therapist thinks through the issues carefully in terms of consistency with their theoretical orientation and personal approach; (b) the therapist considers carefully the clinical implications of the policy for the individual client; and (c) both therapist and client clearly understand the ground rules, including any charges for these “extra” sessions including phone consultations.

It can also be important to clarify under what circumstances, if any, the therapist will be available for e-mail communication and how privacy issues will be addressed; for example, do any third parties have access to the therapist’s or the client’s e-mail accounts? Some therapists have been surprised to receive an unexpected e-mail from a client who has searched the internet and discovered the therapist’s supposedly “personal” e-mail address. Both therapist and client must clearly understand whether e-mail can be used to schedule and cancel sessions, check in between regularly scheduled office sessions, or provide therapy or counseling over the internet. Informed consent should be provided given the limitations of e-mail privacy (see [Chapter 16](#)), and about any additional costs for responding to questions via e-mail.

## **VACATIONS AND OTHER ANTICIPATED ABSENCES**

Extended and sometimes even brief interruptions in the schedule of appointments can stir puzzling, strong, or even overwhelming reactions from a client. What is important is that therapists give the client adequate notice of the anticipated absence. If therapists take a two-week vacation at the same time each year or travel frequently for various reasons, there may be no reason to withhold this information from the customary orientation provided to a new client.

Therapists who find that they will be spending six weeks on a camping trip, sea cruise, or meditation retreat during the coming year should consider carefully if there is any compelling clinical or practical reason to withhold this information from a client as soon as

reservations are made. While most clients may take such absences in their stride, others may have intense reactions. This is, of course, grist for the therapeutic mill, but the ethical responsibility is to allow opportunity for such work to occur. Prompt notification of anticipated therapist absences minimizes the likelihood that a client will experience a psychologically paralyzing traumatic shock, gives the client maximal time to mobilize the resources to cope with a therapist's absence in a way that promotes independence and growth, and enables the client to become aware of their reactions and work with them during the sessions before and after the absence.

## **SERIOUS ILLNESS AND OTHER UNANTICIPATED ABSENCES**

Both therapists and clients tend to find comforting the myth that the therapist is immortal and invulnerable (Pope et al., 2006).

Therapists may relish the feeling of strength and of being a perfect caregiver that such a fantasy, which sometimes occurs on an unconscious level, provides. Clients may soothe themselves—and avoid confronting some personal issues—with the fantasy that they are being cared for by an omnipotent, immortal parental figure.

Although we have not completed our careful study of every therapist who has ever lived—for which we wildly under-budgeted only six weeks to conduct the interviews—our preliminary results suggest that there has yet to appear a therapist who is immortal and invulnerable. For all of us who are mortal and vulnerable, it is important to prepare for those unexpected times when we are suddenly unavailable to our clients (see [Chapter 17](#)).

## **STEPS FOR MAKING HELP AVAILABLE IN A CRISIS**

Once clients clearly understand how to contact the therapist between regularly scheduled appointments, therapist and clients can discuss how to prepare for times when these plans aren't enough. A client, for example, may experience an unanticipated crisis and be unable to reach the therapist promptly by telephone because the therapist's



line is busy for an extended time, the therapist's smart phone mishandles the client's call, the therapist is in session with another client who is in crisis, or any number of other typical or once-in-a-lifetime delays, glitches, or human errors. For the reasons cited earlier, planning for such "unanticipated" breakdowns can enable access to prompt clinical services in time of crisis.

If the client's need for help is urgent and the therapist can't be reached, is there a colleague who is providing coverage for the therapist? Some settings, such as group practices and community mental health centers, assign clinicians to serve on-call rotations so that someone is always available in a crisis. However, many therapists, particularly those in solo independent practice, may need to create their own plans to provide ensure emergency coverage.

Deciding how to arrange for coverage for a specific client is complex. Perhaps the first question is what sort of information the covering clinician will be provided about the client. Will the covering therapist receive a complete review and periodic update of the client's clinical status, treatment plan, and therapeutic progress? Will the covering therapist have access to the client's chart? Will the covering therapist keep a separate set of notes regarding information supplied by the primary therapist? To what extent will the covering therapist need to secure independent informed consent for treatment by the client? The more foreseeable or the greater the risk is that the client will experience a serious crisis demanding prompt intervention, the more compelling the reason for the primary therapist to brief the covering therapist in a careful, thorough manner.

Once the therapist has determined what degree of coverage fits a specific client, a second question is how to introduce the possibility of, or actually implement, such coverage affecting the client's status or treatment. Some clients might feel greatly reassured to know that the therapist is taking their responsibilities seriously and is carefully thinking through possible, even if unlikely, treatment needs. Other clients may become alarmed and feel as if the therapist is predicting that a crisis will occur. Still other clients may stall in their progress; the strict privacy and confidentiality of therapy is essential for them, and the knowledge that the therapist will be sharing the contents of sessions with the covering therapist inhibit their ability to explore

certain issues or feelings. In many cases, discussion between the therapist and client of the question of whether specific coverage will be provided is useful therapeutically.

If you decide to provide specific coverage, a third question is what best serves the client's right to adequate informed consent for sharing information with the covering therapist and otherwise making arrangements for the coverage.

A fourth question addresses the selection of a clinician to provide the coverage. The primary therapist may incur legal (i.e., malpractice) liability for negligence in selecting the coverage. If, for example, the clinician providing the coverage mishandles a crisis situation or otherwise harms the client through acts or failures to act, the primary therapist may be held accountable for failure to screen and select an appropriate clinician.

However, the ethical and clinical issues are much more subtle than the legal aspects. It is important to select a clinician who is well trained to provide the type of care that the client may need. The primary therapist may be tempted to select a clinician solely on grounds of expedience. The primary therapist may know that the clinician is not a very good one and is perhaps less than scrupulous in professional attitudes and actions. Furthermore, the primary therapist may be aware that the clinician does not tend to work effectively with the general client population that the therapist treats. Nevertheless, the therapist may push such uncomfortable knowledge out of awareness because this particular clinician is handy, and it might take considerable effort to locate an appropriate and trustworthy covering therapist. As in so many other situations discussed in this book, the Golden Rule seems salient: If we were the client, or if it were our parent, spouse, or child who desperately needed help in a crisis when the primary therapist is unavailable, if the careful handling of the crisis were potentially a matter of life and death, what level of care would we believe adequate in selecting a clinician to provide the coverage? If, for example, our parent became suddenly despondent, received a totally inadequate response from the clinician providing the coverage, and committed suicide, would convenience seem sufficient rationale for the primary therapist's selection of that clinician to provide the coverage?

If no clinician has been identified to provide coverage or if the identified clinician is for some reason unavailable, to whom does the client in crisis turn when the primary therapist is unavailable? It may be useful for the client to locate a psychiatric hospital, a general hospital with psychiatric services, or other facility providing emergency psychiatric services. There are at least five crucial questions:

1. Is the facility nearby and physically accessible in light of any client disabilities, the need to pass through areas that are dangerous, etc.?
2. Are the services available on a 24-hour basis? If the crisis occurs in the middle of the night, on a weekend, or on a holiday, will the client find help available?
3. Can the client afford to use the facility? Some facilities charge exceptionally high prices and may offer services only to those who can provide proof of ability to pay—for example, an insurance policy currently in effect.
4. Does the client know where the facility is located and its contact information? Especially during a crisis, even basic information (such as the name of a hospital) may be hard to remember. In some instances—for example, both the therapist and client believe that there is a high risk for a crisis—it may be useful for the client to write down the name of the hospital, the address, and the telephone number. Clients can program the name and contact information on their cell phone, carry the information with them, and consider having the information readily available near the telephone at home. Sometimes close friends or family play a vital role in supporting a client in times of crisis. If the circumstances are appropriate, the client may also wish to give this information to a close friend or relative.
5. Do both therapist and client have justifiable confidence that the facility provides adequate care? Substandard care may make a crisis worse. Sometimes no care from certain facilities may be better than an inappropriate response.

If the primary therapist, secondary therapist, and designated facility are all unavailable—for whatever reason—in time of crisis, is there a

hotline/helpline or other 24-hour telephone service that can provide at least an immediate first-aid response to the crisis and attempt to help the client locate a currently available source of professional help? Some areas have 24-hour suicide hotlines/helplines. There may be a 24-hour crisis line providing help for individuals with certain kinds of problems. At a minimum, such a telephone service may help a client survive a crisis. For some clients (e.g., those who cannot afford a telephone or access to secure e-mail at their residence), identifying channels of communication that will be accessible in times of crisis will be an important part of the planning.

If all of the resources noted are inaccessible to the client, the client may nevertheless be able to dial 911, the operator, or a similar general call for emergency response. The client may then be guided to sources of help, or, if appropriate, an ambulance or other emergency response may be dispatched.

Whenever a therapist is assessing a client's resources for coping with a crisis that threatens to endanger or overwhelm the client, it is important to assess not only the professional resources but also the client's social resources. Individual friends and family members may play key roles in helping a client to avert or survive a crisis (although a friend or family member can also spark, magnify, complicate, or prolong a crisis). In some instances, nonprofessional groups, such as Alcoholics Anonymous, may provide access to support. The presence of such social supports gains in relative importance when the client's access to professional help is difficult. For example, some clients (especially those who cannot afford a telephone or internet service) cannot find access to a telephone, particularly if they are experiencing a crisis in the middle of the night. Online groups and social supports may be helpful for some. For many clients, the awareness of such social supports helps them to feel less isolated and thus less vulnerable to becoming overwhelmed by a crisis.

Sometimes therapy begins with the client in crisis and that the client's access to a team of clinicians or caregivers may be useful. The *American Psychologist* presented the next case study illustrating a situation in which the immediate creation of a crisis team proved helpful when a person without funds or coverage needed help:

In an instance in which a woman required daily sessions during a critical time in her life, colleagues accepted [the therapist's] request that they serve pro bono as an interdisciplinary team, offering detailed daily consultation to him and providing periodic psychological assessment and clinical interviews for the woman. Her meetings with diverse professionals let her know that many people cared about her. These colleagues mobilized to help a battered woman, a victim of multiple sexual assault, now penniless and homeless, living in her car and hiding from a stalker. She and [the therapist] began meeting daily (later gradually reduced to weekly) for crisis intervention. They agreed that the first priority was her safety. [The therapist] gave her the number of an old college friend in another state. The friend immediately wired her \$500 for food and housing and an airline ticket with an open date for use any time she felt in danger from the stalker. The friend asked her not to repay this loan directly to him but rather to give the money to someone else for whom it would make a difference as it did for her now. Within a year, the woman had taken legal action against the stalker and recovered enough to support herself (Pope, 1995, p. 242).

## ENDINGS

Therapists are ethically required to end the therapeutic relationship under certain conditions. The APA Ethics Code (APA, 2017a) Standard 10.10a clarifies responsibilities to end the therapeutic relationship when appropriate by indicating that “psychologists terminate therapy when it becomes reasonably clear that the client no longer needs the service, is not likely to benefit, or is being harmed by continued service” (p. 15). The Canadian Psychological Association Code of Ethics (CPA, 2017a) Standard II.37 requires that psychologists “terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed” (p. 23).

In an ideal world, therapists provide continuing service as long as it is needed and beneficial. But few of us have been able to find that particular world, let alone move there. Insurance companies may

refuse to approve additional sessions, despite the therapist's professional judgment that terminating services would be harmful—and perhaps fatal—for a client judged to be at risk for suicide.

Insurance companies may provide only a limited number of sessions annually for clients without the diagnosis of serious mental illness. Some clients who do not meet the relevant criteria may suffer crises that cannot be safely or effectively addressed in the limited number of sessions. For some such patients, interrupting treatment, even though in accordance with the insurance company's policies and procedures, may constitute abandonment.

How do therapists and clients know when to terminate therapy? One strategy is for the therapist and client to review from time to time the presenting concerns, goals, and progress. This discussion helps clarify how much has been accomplished, as well as what still needs to be addressed, and whether the client and therapist wish to continue. Some clients are able to easily announce that they are ready to stop coming or that their employer has switched insurance and that they would like your help to choose their next therapist from their new therapist list. Others may panic at the idea of stopping without more lead time and preparation.

The issue becomes more complex if the therapist believes therapy is going well, but the client either is either wavering about continuing or wants to stop but finds it hard to say so. Sometimes these clients just stop coming. They say they'll call to schedule the next appointment or else cancel a scheduled appointment, but in either case you don't hear from them again. In addition, many people use therapy in short installments and drop out for a while, later returning to the same clinician or starting with a new therapist. When clients who seemed successfully engaged in therapy stop coming, a note or call to provide them with options can be helpful and provide useful information. Examples of options may include scheduling a review and termination session, or returning to therapy.

When approaching termination, therapists bear an ethical responsibility to address questions that tend to arise around termination. The American Psychological Association's Ethical Principles and Code of Conduct (2017a) Standard 10.10c states the responsibilities of a therapist to engage in a termination process:

“Except where precluded by the actions of clients/patients or third-party payors, prior to termination psychologists provide pretermination counseling and suggest alternative service providers as appropriate” (p. 15).

The Ethics Code notes that we have the right to terminate therapy when we are threatened by the client or patient or another person with whom the client or patient has a relationship (Standard 10.10b). This is an attempt to balance the importance of therapist self-care with the responsibilities to the client. It is probably not appropriate to terminate when a client is in crisis.

Vasquez et al. (2008, pp. 661–662) provide 12 recommendations to help make sure that termination goes as well as possible and meets the highest ethical and clinical standards:

1. Provide patients with a complete description of the therapeutic process, including termination; obtain informed consent for this process at the beginning of treatment, and provide reminders throughout treatment.
2. Ensure that the therapist and client collaboratively agree on the goals for therapy and the ending of therapy.
3. Provide periodic progress updates that include discussions of termination and, toward the end of therapy, provide pre-termination counseling.
4. Offer a contract that provides patients with a plan in case the therapist is suddenly unavailable (including death, or financial, employment, or insurance complications).
5. Help clients develop health and referral plans for post-termination life.
6. Make sure you understand termination, abandonment, and their potential effects on patients.
7. Consider developing (and updating) your professional will to proactively address unexpected termination and abandonment, including the name(s) of colleagues who will contact current patients in the case of your sudden disability or death.

8. Contact clients who prematurely terminate via telephone or letters to express your concern and offer to assist them.
9. Use the APA Ethics Code ... your state practice regulations, and consultation with knowledgeable colleagues to help guide your understanding and behavior in regard to therapy termination.
10. Review other ethics codes for discussions of abandonment. The American Counseling Association ... and the American Mental Health Counselors Association ... contain prohibitions against abandonment.
11. Make the topic of termination a part of your regular continuing education or professional development.
12. Be vigilant in monitoring your clinical effectiveness and personal distress. ... Therapists who self-monitor and practice effective self-care are less likely to have inappropriate terminations or clients who feel abandoned.

## CONCLUSION

Constant ethical awareness—particularly a careful, imaginative awareness—and a sense of personal responsibility play a fundamental role in making sure that clients have adequate access to the help they need, particularly in times of crisis when the therapist can't be reached. In hospital and similar settings, the *apparent* (though unfortunately not always actual) abundance of staff may lead to a diffusion of responsibility in which no one is available to help a patient in crisis. Levenson and Pope (1981), for example, present a case study in which a psychology intern was assigned responsibility to promptly contact a suicidal individual who had been referred to the outpatient unit by the crisis service and arrange for conducting an intake assessment. The intern, however, was absent from the staff meeting at which the assignment was made. His supervisor, also absent from the meeting, had sent him to attend a two-day training session at another institution. During the next few days, the individual committed suicide.



The hospital's thanatology committee concluded that the crisis service had handled the situation appropriately in referring to the outpatient unit. The outpatient unit itself was not involved in the postmortem investigation because, according to the hospital's procedures, outpatient cases are not opened until the potential patient is contacted by the outpatient unit for an intake screening. The intern himself struggled with his reactions to these events. Among his conclusions was that he had "at some level internalized the organizational view that no one is really responsible" (p. 485).

Imagination is useful in creating an awareness of the types of crises a client might experience and what difficulties they might experience in trying to gain timely access to needed resources. The scenarios for discussion presented at the end of this chapter provide examples.

Thinking things through in advance on a worst-possible-case basis can help the therapist to anticipate the devious ways in which Murphy's law pays surprise visits in our work. If we look back from that imaginative perspective, we can ask ourselves: If any of the worst-possible-case outcomes had happened, what, if anything, do we wish we would have done to prevent them, lessen their impact, or prepare for addressing these events?

No therapist is infallible. The most careful and confident assessment of a client's potential for crisis can go wrong for all sorts of reasons. But we need to take into account our own weaknesses, blind spots, biases, and other fallibilities so that we can plan better for the unexpected, especially the worst-possible-case scenarios.

Similarly, imaginative approaches can create accessibility to needed resources. For example, a therapist was treating an extremely isolated, anxious, and troubled young woman pro bono because of the client's lack of money. From time to time, the client became overwhelmed by anxiety and was acutely suicidal. However, she had no practical access to hospitalization because of her financial status and the absence in the community of sufficient beds for those who lacked adequate funds or insurance coverage. In similar cases, the therapist had encouraged clients to make arrangements to have a trusted friend come by to stay with them during periods of extreme dysfunction and suicidal risk. However, this client was so socially isolated that she had no friends, and the therapist was unable to

locate an individual—from local church and synagogue groups or from hospital volunteer organizations—who could stay with her in times of crisis.

Determined to come up with some arrangement that would help ensure the client's safety and welfare, should she experience a crisis and the therapist be unavailable, the therapist and client finally hit on the possibility of her going to the local hospital's waiting room (the waiting room adjacent to the emergency room was open around the clock). The therapist contacted hospital personnel to make sure that they would not object to the client showing up at odd hours to sit for long periods of time in the waiting room.

The arrangement worked well during the remaining course of therapy. According to the client, simply knowing that there was someplace for her to go helped her to avoid becoming completely overwhelmed by external events or by her own feelings. On those occasions when she did feel that she was in crisis and at risk for taking her own life, she found that going to the hospital waiting room seemed helpful; it made her feel more active and aware that she was doing something for herself. Being out of her small, depressing, and claustrophobic apartment, sitting in a "clean, well-lighted place," and being around other people (who, because they were strangers, would be unlikely to make, in her words, "demands" on her) were all factors that helped her feel better. Knowing that there were health-care professionals nearby (even though she had no contact with them) who could intervene should her impulses to take her own life become too much for her, and aware that she was carrying out a "treatment plan" that she and her therapist had developed together, helped her to feel calmer, less isolated, and comforted in crisis.

The waiting room strategy enabled this client, who was highly suicidal, to be treated safely, although hospitalization was not feasible, during the initial period of therapy when outpatient treatment alone seemed, in the judgment of both the therapist and an independent consultant, inadequate and when the client could not afford additional resources. It made imaginative use of resources that were readily available in the community and were accessible to the client.

Understanding the degree to which individual clinicians and mental health organizations will be accessible and will make help available is a crucial aspect of the client's informed consent, the focus of the next chapter.

# SCENARIOS FOR DISCUSSION

[Chapters 15](#) through [27](#) in this book end with scenarios, each accompanied with a set of questions for discussion. This approach had been used in *Sexual Feelings in Therapy: Explorations for Therapists and Therapists-in-Training* (Pope et al., 1993). Although we have created original vignettes for the other chapters in this book, the following scenarios and questions are adapted from *Sexual Feelings in Therapy* and *What Therapists Don't Talk About and Why: Understanding Taboos That Hurt Us and Our Clients* (Pope et al., 2006).

You notice that it is exactly 2:00 P.M., the time you are scheduled to meet a new client, and your waiting room is still empty. The telephone rings. It is your new client. She asks if you would mind coming out to the front steps. You're puzzled but say "I'll be right there." When you go to the front steps, you see your new client in her wheelchair at the bottom of the steps.

- How do you feel?
- What thoughts go through you mind?
- What do you think is the first thing you would say?
- What would you like to do?
- What do you think you would do?

...

You are late getting to the airport, in danger of missing your plane (during a holiday season, so it would be very hard to get booked on a later flight), when you receive an emergency call from a local hospital. One of your therapy patients has tried to commit suicide and has been hospitalized. The client is desperate to talk with you in person—refusing to talk over the telephone—immediately about having just discovered a horrifying secret. You have no idea what the "secret" is.

- How do you feel?

- Are there any feelings about the patient, the emergency room staff person who called you, or the situation that are particularly difficult to acknowledge?
- What are your immediate options?
- What do you think you would do?
- To what extent, if at all, do any concerns about a malpractice suit influence your judgment?

...

A new client begins the first session by saying “I need therapy because I lost my job, and my partner, whom I lived with for three years, left me for someone else. I don’t know whether to kill myself, kill my boss, kill everyone else, or just try to hang on since now I’m all my little baby has left.”

- How do you feel?
- Assuming that you cannot rule out that the person’s threats are serious, what steps do you take in clarifying access to you and others before the client leaves this first appointment?
- What concerns, if any, do you have about this person’s adequate access to prompt and adequate help?
- Is there anything you wish you would have told the person about your availability or anything else before the person made these statements?

...

You work for a large Employee Assistance Program providing individual and family therapy full time. You meet with your manager late Friday afternoon and are told that the company has been taken over by a new owner, who is merging several companies. There are now too many therapists, and it is with the greatest regret that your manager tells you that reorganization has led to your no longer being retained by the company. This is your last day. Your clients are being reassigned. You will be allowed to return to your office only with a security guard, you will be able to stay only 30 minutes to clean out your desk, and

you will not be allowed to copy any telephone numbers or other information or to take any charts with you.

- How do you feel?
- What are your options?
- What steps do you think you would take?
- Would you make any effort to contact the clients you had been seeing? If so, how and what would you tell them?

• • •

A former client, whom you had seen in therapy for three years, called in crisis. She said that she had started therapy with someone else, given a change of jobs and a new insurance plan. You were not listed on the new insurance provider list. However, she cannot reach that new therapist during her crisis. Besides, she feels more comfortable with you.

- What do you feel?
- Do you have any legal or ethical obligations to this former client, and, if so, what are they?
- If you agree to talk with this client on the telephone for a while or meet with her for one or more crisis sessions, what legal, ethical, or clinical responsibilities, if any, do you have in regard to coordinating your work with her current managed care therapist?
- Do you chart this telephone call?
- Do you have a clear policy regarding contacts with former clients? If so, are clients made aware of this policy prior to termination?

# Chapter 16

## INFORMED CONSENT AND INFORMED REFUSAL

Ethical clinical services show respect for each patient's freedom, autonomy, and dignity. Informed consent—perhaps the most extensively recognized of the ethical safeguards in clinical work (Amer, 2013)—reflects that respect. In general, informed consent is the process of describing to patients the purpose, risks, and benefits of the services they will receive. Clinicians provide informed consent in order to ensure that clients know, understand, and are able to make an informed decision on whether they want to participate in the services we offer or refuse. Ethics codes highlight consent as a key value. The APA (2017a) ethics code sets forth five specific standards for informed consent (Sections 3.10, 10.01, 10.02, 10.03, and 10.04). The CPA (2017a) code emphasizes the many ethical aspects of consent, setting forth 11 specific standards (I-16–I-26) under the heading “Informed Consent;” an additional four standards (I.27–I.30) under the heading “Freedom of Consent;” and mentioning the term “consent” 58 times throughout the code. Section III-13 of the Canadian Code highlights the care we need to take to make sure clients have all the information they need regarding “integrity of relationships.” In addition, to be fully informed, valid, and meaningful, consent needs to be:

Clear and straightforward about all information needed to establish informed consent or any other valid written or unwritten agreement (e.g., fees, including any limitations imposed by third-party payers; relevant conflicts of interest; relevant business policies and practices; contact information of accountability bodies; mutual concerns; mutual responsibilities; ethical responsibilities of psychologists; likely experiences; possible conflicts; possible outcomes; and expectations for processing, using, and sharing any information generated.

The emphasis on consent in the codes may fail to make it into our training, and if our training fails us, we may not be well prepared to provide true informed consent to those who come to us for help (For the potential disconnect between codes, training, and conduct, please see the section “Keep Codes in Context” in [Chapter 27](#)). To illustrate, in their study of how trainees learn about informed consent in therapy, Blease et al. (2020) found that among the problems was *ethics training by osmosis* and the role of the *hidden curriculum*, in which “unintended lessons communicated to trainees are likely to have reinforced omissions, oversights, and a general laxity about securing ethical informed consent” (para. 43). They call on organizations like APA to provide greater clarity to educators on this topic.

## **FRIGHTENING FORMS, EMPTY FORMALITIES, AND NEEDLESS BURDENS**

Sharpening our ethical awareness in the area of informed consent helps us avoid common pitfalls. For example, nothing blocks a patient’s access to help with such cruel efficiency as a bungled attempt at informed consent. We spend time and resources to make our offices warm and inviting, welcoming, and accessible to all. However, it is equally important to also help patients navigate and understand the dense forms (which clerks may shove at them when they first come through our door), our set speeches full of noninformative information, and our nervous attempts to meet externally imposed legalistic requirements such as the United States (US) Health Insurance Portability and Accountability Act (HIPAA) or the Canadian Personal Information Protection and Electronic Documents Act (PIPEDA). Indeed, even the hardiest patients will encounter some obstacles to fully grasp all of the legalistic content.

One trap we can fall into is resenting consent as a formality to be gotten out of the way instead of considering it an essential part of the patient’s rights and our clinical work. Daniel Sokol (2009) wrote:



[W]hat is the most redoubtable obstacle to valid consent? It is the still prevalent attitude that obtaining consent is a necessary chore, a ... hurdle to jump over. Too often “consenting” a patient is reduced to the mechanistic imparting of information from clinician to patient or, worse still, the mere signing of a consent form, rather than the two-way, meaningful conversation between clinician and patient it should be. If we can change this mindset [sic] and view obtaining consent as an ethical duty first and foremost, one that is central to respecting the autonomy and dignity of patients, then we will have taken a major step towards first class consent and uninterrupted lunches (p. 3224).

Viewing consent as an obligation and burden makes it hard to meet the needs of patients. Discussing their questionnaire study of patients’ perceptions of written consent, Andrea Akkad and her colleagues (2006) wrote:

Our findings add to evidence showing that even when the consent process satisfies administrative and legal requirements, patients’ needs may not be met.... Though patients did identify several important advantages of the consent process, there was substantial uncertainty about the implications of signing or not signing the consent form.... Many patients did not see written consent as functioning primarily in their interests nor as a way of making their wishes known.... Although there is no straightforward relation between knowledge of rights and ability to exercise those rights, a lack of awareness of the limits and scope of consent is clearly undesirable, potentially causing patients to feel disempowered and lacking in control (p. 529).

Thus, a first step in remedying the situation is to recognize that informed consent is not a static ritual but a useful process.

## **PROCESS OF INFORMED CONSENT**

The CPA (2017a) Ethics Code notes that psychologists “recognize that obtaining informed consent is a process that involves taking time to establish an appropriate trusting relationship and to reach an agreement to work collaboratively, and may need to be obtained more than once” (p. 14). The process of informed consent provides

both the patient and us with an opportunity to make sure that we adequately understand our shared venture. It is a process of communication and clarification. Do we understand why the patient is seeking our help? Do we know what the patient expects, hopes, or fears from therapy? Does the patient understand the approach we will be using to assess and address the problem? Does the patient know the common effects of using such an approach and alternative approaches to their problem?

The UK Supreme Court (2015) described the process that creates an agreement to work together. It includes

dialogue, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision. This role will only be performed effectively if the information provided is comprehensible. The doctor's duty is not therefore fulfilled by bombarding the patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form (Montgomery v. Lanarkshire Health Board, 2015).

Culture affects this process of communication and clarification. For example, the therapist might be from the dominant culture while the patient might be a recent immigrant who is currently in the process of adapting to the majority culture. Chong Wang (2009) points out that level of acculturation can influence how the client understands and makes sense of the process. For instance, level of acculturation can influence the desire for independent decision-making, ways of relating within cultural contexts, ways in which psychological disorders, authority, and so on are perceived and described, and what they think can help them to feel better (for more, see also Kleinman et al., 1978).

Wang suggests 11 helpful steps to assess level of acculturation:

1. In general, what language(s) do you read and speak?
2. What was the language(s) you used as a child?
3. What language(s) do you usually speak at home?

4. In which language(s) do you usually think or dream?
5. What language(s) do you usually speak with your friends?
6. In what language(s) are your preferred TV/radio programs?
7. In general, what language(s) are the movies, TV, and radio programs you prefer to watch and listen to?
8. Your close friends are ...?
9. You prefer going to social gatherings/parties at which people are ...?
10. The persons you visit or who visit you are ...?
11. If you could choose your children's friends, you would want them to be ...?

In addition to these questions, level of acculturation can be observed by noting the degree to which individuals follow the traditions, values, and beliefs of their traditional culture, the host culture (or dominant culture) or both cultures. Culture may also influence whether a form signed by the client is necessary and appropriate. The CPA (2017a) code states:

If signed consent forms are required by law or desired by the psychologist, the individuals or groups giving consent, or the organization for whom the psychologist works, establish and use signed consent forms that specify the dimensions of informed consent or that acknowledge that such dimensions have been explained and are understood.

But the following section notes that psychologists “accept and document non-written consent (e.g., oral, a verbal agreement, a handshake, or other culturally normative exchange) in situations in which signed consent forms are not acceptable culturally or in which there are other good reasons for accepting non-written consent” (p. 14).

Informed consent also involves making decisions. The patient must decide whether to undertake this course of assessment or treatment, whether to start now or later, and whether to try a different approach or a different therapist.

We therapists must decide whether the patient is competent to exercise informed consent. For example, young children, adults who have been declared legally incompetent, and those who have significant cognitive impairment (e.g., neurodegenerative disease, impaired intellectual abilities) may not be capable of providing fully informed consent.

The presence of a severe psychological disorder requiring hospitalization does not by itself mean that the patient lacks the ability to give or refuse meaningful consent to therapy. Debra Pinals (2009) wrote:

Adult patients with psychotic disorders are not automatically or always incompetent. Research has shown that most inpatients with mental illness have capacities to make treatment decisions similar to persons with medical illness. Patients with schizophrenia, however, have deficits relevant to capacity to make treatment decisions more often than patients with medical illnesses and depressive disorders. Patients with depressive disorders also are more likely to have some decision-making impairment compared with persons with medical illnesses (p. 35).

If informed consent is not possible, we therapists must decide whether the situation justifies an intervention in the absence of fully informed consent. We must also consider whether a fully competent patient has the information necessary to: (a) make an informed decision; (b) adequately understand that information; and (c) provide consent voluntarily.

Patrick O'Neill, a former president of the CPA, suggests that the process of informed consent take the form of negotiation:

While most therapists recognize that negotiation can clear up clients' misconceptions, fewer recognize that negotiation is also a vehicle for clearing up the *therapist's* misconceptions. An open dialogue can make the therapist aware of features of the case that depart from both the therapist's model and his or her previous experience, and thus it serves as a corrective to the representativeness and availability biases (1998, p. 176).

Finally, informed consent is a continuing process. Williams (2008) wrote: "Obtaining consent is not a discrete event; rather, it is a

process that should occur throughout the relationship between clinician and patient” (p. 11). The patient may consent to an initial psychological, neuropsychological, and medical assessment as well as to a course of individual or group therapy based on an initial, very provisional treatment plan. However, later the assessment results, the patient’s response to treatment, and changing circumstances may lead to a radical revision in the treatment plan. In such cases, the patient needs to understand the revisions made and agree to them.

## **THE FOUNDATION OF INFORMED CONSENT**

Informed consent is one way we try to make sure that the patient’s trust is justified, demonstrate that we are not trying to abuse our power, and make sure we express our caring in ways that the patient understands and agrees to. Sadly, for many decades, healthcare ethics paid little attention to this important process. How did informed consent move from invisibility to center stage? Several key court cases gave strong shoves to the healthcare professions, insisting that they recognize patients’ fundamental right to informed consent. These decisions often involved medical practice, but much of the reasoning applies to assessment and psychotherapy.

Traditionally, the healthcare professions took an arrogant, authoritarian approach, the physician alone deciding what treatment the patient received. The Hippocratic Oath lacked the principle of informed consent. During the centuries leading up to the modern era, physicians tended to share the belief that “the experts” decisions should not be questioned, especially by patients who lacked the training, knowledge, and objectivity to know what was good or what was best for them. This approach violated “the value of respect for persons’ autonomy and their right to define their own goals and make choices designed to achieve those goals” (Grady, 2015, p. 855; see also Campbell et al., 2010; Robeson & King, 2014).

A legal case involving a hospital in New York marked a landmark shift away from this authoritarian approach. In 1914, Judge Benjamin Cardozo, who later became a justice of the US Supreme Court, wrote that “every human being of adult years and sound mind has a right to determine what shall be done with his own body” (*Schloendorff v. Society of New York Hospital*, 1914, p. 93).

It was not so much that this case changed the customary procedures by which physicians went about their work; it was more that Judge Cardozo articulated clearly the idea that it was the patient, rather than the physician, who had the right to decide whether or not to undertake a specific treatment approach. Unfortunately, the implications of this principle slept unnoticed for decades.

The Nuremberg trials and subsequent Nuremberg Code on Medical Intervention and Experimentation focused attention on the importance of informed consent. The trials revealed the horrific and inhumane practices of many healthcare professionals during World War II under the guise of “treatment” and “research” (Adam, 2007; Beauchamp, 2014; Cocks, 1985; Gallagher, 1990; Geuter, 1992; Koenig, 2000; Lifton, 1986; Lopez-Munoz et al., 2007; Muller-Hill, 1988; Pope, 1991; Proctor, 1988; Spitz, 2005; Thieren & Mauron, 2007). The Nuremberg trials and code emphasized the individual’s fundamental right to informed consent or informed refusal of participation in treatment or research. O’Neill (1998) wrote:

The two main ways of protecting the public from the healer are oversight and consent. Throughout most of the history of healing, the emphasis was on oversight: monitoring of professional activity by professional associations, regulatory bodies, or the courts. The Nuremberg Declaration gave a new, privileged position to consent, putting control into the hands of the client (pp. 13–14).

Shuster (1998) noted how easy it could be, when the right to consent or refusal is ignored, to allow purportedly good ends to justify inflicting terrible—sometimes fatal—“treatments” on human beings without their knowledge or consent:

This was the case of ionising radiation research motivated by the cold war and sponsored by the US government for national security. Patients in hospital, children, mentally ill and impaired persons, pregnant women, workers, soldiers, and others were used as experimental subjects often without their knowledge, or that of their families; many believed they were being treated for their medical conditions (p. 976; see also Advisory Committee on Human Radiation Experiments, 1995).

The landmark 1960 Kansas case of *Natanson v. Kline* focused on community standards for making real the patient's right to informed consent. The court reaffirmed the Cardozo principle: "Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body" (p. 1104). The court stated that to make this determination, the patient obviously needed the relevant information. But what information was relevant was left entirely to the community of doctors to decide:

The duty ... to disclose ... is limited to those disclosures which a reasonable ... practitioner would make under the same or similar circumstances .... So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation (p. 1106).

This case exemplifies the *community standard rule*: Informed consent procedures must adhere only to what the general community of doctors customarily do. It also reflects the strong value of autonomy and self-determination that underlies Western law, policy, and ethical decision-making.

In 1972, with decisions handed down by the Federal District Court in Washington, D.C., and the California Supreme Court, the full implications of Judge Cardozo's principle were realized. The reasoning began with the reaffirmation of *Schloendorff v. Society of New York Hospital* and an emphasis that the patient must have relevant information that only the doctor can provide:

The root premise is the concept, fundamental in American jurisprudence, that “every human being of adult years and sound mind has a right to determine what shall be done with his own body....” True consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible (*Canterbury v. Spence*, 1972, p. 780).

To this end, it is the patient, and not the doctor, who must make the final decision. For this decision to be meaningful, it must be based on an adequate range of information provided by the doctor:

It is the prerogative of the patient, not the physician, to determine for himself the direction in which he believes his interests lie. To enable the patient to chart his course knowledgeably, reasonable familiarity with the therapeutic alternatives and their hazards becomes essential (*Cobbs v. Grant*, 1972, p. 514).

This line of reasoning emphasized the exceptional trust and dependence inherent in healthcare, differentiating them from the milder versions of trust and dependence, often dealt with using a *caveat emptor* principle, characteristic of less intense, less intimate transactions in the marketplace:

A reasonable revelation in these aspects is not only a necessity but, as we see it, is as much a matter of the physician’s duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care. It is, too, a duty to impart information which the patient has every right to expect. The patient’s reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject (*Canterbury v. Spence*, 1972, p. 782).



This landmark case law specifically rejected the idea that doctors, through their community standards, could determine what degree of information the patient should or should not have. It was not up to doctors, individually or collectively, to decide what rights a patient should have with regard to informed consent or to determine those rights indirectly by establishing customary standards regarding what information was and was not to be provided. Patients were held to have a right to make an informed decision, and the courts were to guarantee that they had the relevant information for making the decision. The court observed in *Canterbury v. Spence*:

We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition .... Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves (1972, pp. 783–784).

The case law clearly states the need for doctors to provide adequate relevant information regardless of whether the patient actively asked the “right” questions in each area. As a result, doctors were prevented from withholding or neglecting to provide relevant information because a patient did not ask. The doctors were seen as having an affirmative duty to make an adequately full disclosure:

We discard the thought that the patient should ask for information before the physician is required to disclose. *Caveat emptor* is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions: it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire.... Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequalities (*Canterbury v. Spence*, 1972, p. 783; see also (*Montgomery v. Lanarkshire Health Board*, 2015, which emphasized this principle).

Realizing that some patients would certainly choose not to undertake specific assessment or treatment procedures, the courts emphasized that understanding what might happen as a result of not getting adequate assessment or treatment was as relevant to making an informed decision as understanding the assessment and treatment procedures themselves. Thus, the California Supreme Court in 1980 not only reaffirmed the principles previously set forth in *Canterbury v. Spence* and *Cobbs v. Grant* but also affirmed that patients have a right to informed refusal of treatment as well as a right to informed consent to treatment:

The rule applies whether the procedure involves treatment or a diagnostic test.... If a patient indicates that he or she is going to *decline* a risk-free test or treatment, then the doctor has the additional duty of advising of all the material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. On the other hand, if the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action (*Truman v. Thomas*, 1980, p. 312).

Recognizing that some doctors might be intimidated by the daunting thought of presenting to patients essentially all they had learned during their training and that patients might be ill-suited recipients of jargon-filled lectures, the court emphasized that the patient needed only the relevant information to make an informed decision but needed it in clear, straightforward language: “The patient’s interest in information does not extend to a lengthy polysyllabic discourse on all possible complications. A mini-course in medical science is not required” (*Cobbs v. Grant*, 1972, p. 515).

In summary, in 1970, the courts gave to patients the right to make decisions to accept or reject treatment and gave to doctors the responsibility for making sure that patients had adequate information for making that decision. The California Supreme Court attempted to articulate the basis of this concept of informed consent:

We employ several postulates. The first is that patients are generally persons unlearned in the medical sciences and therefore, except in rare cases, courts may safely assume the knowledge of patient and physician are not in parity. The second is that a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. The third is that the patient’s consent to treatment, to be effective, must be an informed consent. And the fourth is that the patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information upon which he relies during the decisional process, thus raising an obligation in the physician that transcends arm-length transactions. From the foregoing axiomatic ingredients emerges a necessity, and a resultant requirement, for divulgence by the physician to his patient of all information relevant to a meaningful decisional process (*Cobbs v. Grant*, 1972, p. 513).

These principles began to pass from case law into legislation. Section F of Indiana’s *House Enrolled Act of 1984*, for example, stated:

All patients or clients are entitled to be informed of the nature of treatment or habilitation program proposed, the known effects of receiving and of not receiving such treatment or habilitation, and alternative treatment or habilitation programs, if any. An adult voluntary patient or client, if not adjudicated incompetent, is entitled to refuse to submit to treatment or to a habilitation program and is entitled to be informed of this right.

## **ADEQUATE INFORMATION**

The information provided during the consent process will differ according to the professional service (e.g., assessment, therapy) and other factors. However, any consent process can be evaluated in terms of whether it adequately addresses the following set of questions. This list may be useful in planning new consent procedures or reviewing existing approaches to consent in any setting:

- Does the patient understand who is providing the service and the clinician's qualifications (e.g., license status)? If more than one person is involved (e.g., a therapist and clinical supervisor), does the patient understand the nature and implications of this arrangement?
- Does the patient understand the reason for the initial session? Although in many instances patients will have scheduled an initial appointment on their own initiative and for relatively clear reasons, in other instances they may have been referred by others (perhaps an internist or a court) and not clearly understand the reason for the session.
- Does the patient understand the nature, extent, and possible consequences of the services the clinician is offering? Does the patient understand the degree to which there may be alternatives to the services provided by the clinician?
- Does the patient understand actual or potential limitations to the services (e.g., an insurance policy's limitation of coverage to a specific dollar amount) or to the clinician (e.g., the therapist is an intern whose rotation will conclude in 3 months, after which they

will no longer be available to the patient)? Does the patient understand the ways in which the services may be terminated?

- Does the patient understand fee policies and procedures, including information about missed or canceled appointments?
- Does the patient understand policies and procedures concerning access to the clinician, to those providing coverage for the clinician, or to emergency services? For example, under what conditions, if any, will a therapist (or someone else providing coverage) be available by telephone between sessions during business hours, at night, or on weekends? ([Chapter 15](#) discusses these issues.)
- Does the client understand processes and procedures in the case of death or disability of the clinician (see [Chapter 18](#), Creating a Professional Will)?
- Does the patient understand exceptions to confidentiality, privilege, or privacy? For example, does the patient understand the conditions, if any, under which the clinician might disclose information about the patient to an insurance company, the police, or the courts? Does the person understand under what conditions other people in the setting (such as clerical workers, clinical supervisors or consultants, administrative supervisors or other administrative staff, quality control personnel, utilization review committees, auditors, researchers) may learn about the patient and the services provided to them, whether through discussion (case conferences, supervision, consultation) or writings (clinical chart notes, treatment summaries, administrative records)? [Chapter 21](#) provides a discussion of these issues and exceptions.

## **CONSIDERATIONS IN PROVIDING INFORMED CONSENT**

No rigid method can do the work of fulfilling a patient's right to informed consent. No set method can relieve us of a thoughtful response to the unique individual patient.

Informed consent is an ongoing process, not a static set of pro forma gestures. It grows out of the relationship between clinician and patient. It must fit the situation and the setting. Consent must respond not only to the standards of the clinician's professional associations, such as the APA or the CPA, but also to the relevant state and federal laws. It must be sensitive to the client's ability to understand the relevant information (e.g., Is the client a young child, developmentally disabled, suffering from severe thought disorder?) and situation (e.g., Is the patient in the midst of a crisis, referred for mandatory treatment by the courts, being held against their will in a psychiatric hospital?). It must be congruent with the client's culture. We can never do away with human sensitivity, professional judgment, and ethical active ethical awareness.

The following considerations can help us create and nurture the process of informed consent.

## **Failing to Provide Informed Consent**

As we think through the best way to provide informed consent for the individual patient, it may be helpful to keep in mind that this fundamental right is sometimes violated, perhaps often. We can take those instances to justify our own decisions to shortchange a patient's right to give or withhold consent, or we can use those instances as an opportunity to strengthen our ethical awareness and consider the matter from the patient's perspective. How would we feel if we were the patient who had been kept in the dark and given no chance to make a decision on an informed basis?

An example of the withholding of informed consent involved the provision of free medical care to hundreds of US citizens (J. H. Jones, 1981; see also Rivers et al., 1953; U.S. Public Health Service, 1973). The program began in 1932 and continued to 1972. If all we were told was that the government, through what eventually became the *US Public Health Service*, was giving us comprehensive medical care, how would we likely feel? Grateful? Relieved that we would be spared financial burdens? Excited that we would have access to state-of-the-science medical interventions provided by the federal government? Would any of us turn down this rare but wonderful opportunity?

What the participants were not told is that they were being used to study the effects of syphilis when it goes untreated. Treatment for syphilis was in fact withheld from all the individuals. Research procedures were presented as treatment; for example, painful spinal taps were described to the subjects as a special medical treatment.

Although Public Health Service officials denied that there were any racist aspects to this research, participation in the program was limited to African Americans. The 40-year Tuskegee syphilis experiment is one of the most infamous in US history. This horrific experiment led to the institution of federal Institutional Review Boards for protection of human subjects (US Center for Disease Control and Prevention, retrieved February 28, 2010).

Other examples are numerous. To illustrate, for one stretch of time, hospitals performed AIDS tests on virtually all patients without their knowledge or consent, sometimes in direct violation of state law (Pope & Morin, 1991). As another example, Stevens (1990) described a testing center that administered the Stanford-Binet Intelligence Scale so that students could be placed in the appropriate classes at school. The information schools received contradicted what was given to the child's parents. In one case, the report sent to the school "recommended that David be placed in a class for average students;" the report sent to the parents recommended that "David should be placed in a class for superior students" (p. 15). Here is how the testing center explained the policy, "The [report] we send to the school is accurate. The report for the parents is more soothing and positive" (p. 15).

How would we feel if we relied on the government and healthcare professions to provide us with free medical care when in fact they were observing and assessing the consequences of an untreated painful, virulent, usually fatal disease? How would we feel if we went to a hospital for help and were given an AIDS test without our knowledge or permission? How would we feel if we were given completely false information about the results of an intelligence assessment because someone else thought it would be "more soothing"?

## **Benefits of Informed Consent**

Approaching the issue of informed consent, we may, as clinicians, fear that providing adequate information to patients and explicitly obtaining their consent will somehow derail therapy and may in fact have detrimental consequences for our patients. However, research has not supported these fears. Trachsel and grosse Holtforth (2019) note that “beyond legal and moral duty, informed consent can benefit the psychotherapeutic process and outcome” (para. 11). A variety of studies have indicated that the use of informed consent procedures makes it more likely that patients will become less anxious, follow the treatment plan, recover more quickly, and be more alert to unintended negative consequences of the treatment Handler (1990). Moreover, Debra Pinals (2009) describe that “informed consent can enhance the therapeutic alliance and help improve treatment adherence” (p. 33).

## **Limits of Consent**

Informed consent is not a strategy to insulate a clinician from responsibility when performing unethical or illegal acts:

At least one case has suggested that there are limits to what a patient can validly consent to. In that case, several adults were treated with a form of therapy that involved physically beating them. The defendants argued they could not be sued because the plaintiffs had consented to the treatment; however, the Court of Appeals refused to accept the consents as a defense. This decision implies that a patient’s consent will not be deemed valid if acts consented to would otherwise be illegal or contrary to public policy (such as a sexual relationship between therapist and patient). An earlier case held that whether touching is therapeutic or nontherapeutic goes to the essence of the act and may vitiate a consent (Caudill & Pope, 1995, pp. 553–554).

## **Consent for Families and Other Multiple Clients**

When we provide therapy to couples, families, or groups, we have a special responsibility to provide adequate informed consent and informed refusal to each person. We also have the responsibility to address issues specific to therapies involving more than one patient. For example, consider the following questions:



- What are the limits of confidentiality and privilege for material disclosed by one of the patients involved in couples, family, or group services?
- Will the therapist hold confidentially from one family member material disclosed by another family member?
- If so, what effect would that have on the trust of the other family member if that other family member discovers that you have kept information from them?
- If one client receiving couple therapy waives privilege, does the privilege still apply to the other member of the couple?

APA Ethics Code (APA, 2017a) standards 10.02 (a) and (b), Therapy Involving Couples or Families, describes the importance of clarifying who the patient is and the relationship the psychologist will have with each person involved. The standard also provides guidance in addressing conflicting roles, should they arise.

Issues related to informed consent are best clarified at the outset of the treatment, and on a continuing basis to clarify conflicts or potential conflicts that might arise during the therapy process. The 2002 APA Ethics Code included a new standard 10.03, Group Therapy, that requires that “when psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality” (p. 1073). Thus, psychologists must describe at the outset of group therapy the unique roles and responsibilities of both therapist and patients in the group therapy, including the fact that while group members are advised to maintain confidentiality about other group members, they are not held to legal liability or ethical codes of conduct. It may be helpful, although not required, to have group members sign an informed consent document, including the group rules and guidelines.

## **Unequal Opportunity for Informed Consent**

It is crucial that all our clients have equal access to informed consent. Unfortunately, research suggests that some clinicians may use factors such as race and income level to justify short-circuiting the

informed consent process for some clients. For example, in an examination of informed consent practices, Benson (1984) found that a patient's race and socioeconomic status was systematically related to whether important information was disclosed to them.

In experiments when the FDA declared an exception to informed consent requirements on people who were unresponsive when given a life-threatening event considered so urgent that surrogate consent was allowed, those selecting the “virtual guinea pigs” in these experiments showed a significant preference for using Black people. This selection among this vulnerable population is an echo of the Tuskegee study's preference for experimenting on Black people. Black people were chosen so far out of proportion to the general population that they ended up constituting almost a third of the research sample (29.3%) in contrast to their representation in the general population (13.4%) at the time (Feldman et al., 2018; see also Serchen et al., 2020).

## **Cognitive Processes**

Clinicians must maintain up-to-date knowledge of the evolving research and theory regarding the cognitive processes people use to make decisions (see Arbuthnott et al., 2006; de Bruin et al., 2015; Douglas & Bigby, 2020; Hess, Lipner et al., 2015; Hess, Strough et al., 2015; Kahneman, 2011; Kleespies, 2014; Taleb, 2010; Zsombok & Klein, 2014). This body of research and theory can help us understand the factors that influence clients who are choosing whether to participate in assessment or treatment procedures.

At a Harvard University hospital, McNeil, Pauker, Sox, and Tversky (1982) presented individuals with two options based on actuarial data concerning patients suffering from lung cancer. The data indicated whether patients had chosen a surgical or a radiological treatment for their cancer and what the outcome had been. Of those who chose surgery, 10% died during the operation itself, an additional 22% died within the first year after the surgery, and another 34% died within five years. Of those who chose radiation therapy, none died during the radiation treatments, 23% died within the first year, and an additional 55% died by the end of five years.

If you were given those actuarial data, which intervention would you choose? When these data were presented, 42% of the participants in the study indicated that they would choose radiation. Note that the data were presented in terms of mortality—the percentages of patients who died. When the same actuarial information was presented in terms of percentages of patients who survived at each stage—for radiation, 100% survived the treatment, 73% survived the first year, and 22% survived five years—only 25% chose radiation. The change from a mortality to a survivability presentation caused a change in the way individuals cognitively processed the information and arrived at a decision.

Because our interventions may have profound effects for our patients and the decisions they may make regarding whether to begin therapy and what sort of therapeutic approaches to try are significant, we have an important ethical responsibility to attend carefully to the form in which we present information relevant to those decisions.

## **Problems with Forms**

Many of us may be so eager to start doing therapy that we try to avoid talking with our clients about consent issues. We try to push all the responsibility off onto a set form and let the form do the work. Those of us who work in clinics or hospitals may not even handle such forms. When the client shows up for an initial appointment they may be handed an imposing-looking form by the receptionist, asked to read it, sign it, and return it before seeing the therapist. The form itself may have been crafted by the clinic's or hospital's attorney and may not even have been reviewed by a clinician. The wording may be in intimidating legalese and bureaucratic jargon. Such forms may be intended more to protect the organization against successful lawsuits than to help the client understand the options and make reasonable decisions. Bemister and Dobson warn against putting all our trust in forms; they posit, "The extent to which these consent forms are true indicators of consent is debatable" (2011, p. 303, see also Pope, 2015a).

Providing information in written form can be vital in ensuring that clients have the information they need. But the form cannot serve as a substitute for an adequate process of informed consent. At a

minimum, the clinician must discuss the information with the client, allow them to ask any questions they may have, and based on their professional judgment determine whether or not the client has adequate understanding of the relevant information.

Clinicians using consent forms must ensure that their clients have the requisite reading skills. Illiteracy is a major problem in the US; clinicians cannot simply assume that all of their clients can read. Moreover, some clients may not be well versed in English, perhaps having only rudimentary skills in spoken English as a second or third language.

Not only must the client be able to read, but the form itself must be readable. Grundner (1980) noted that great effort has been made to ensure that “consent forms have valid content, but little effort has been made to ensure that the average person can read and understand them” (p. 900). He analyzed five forms with two standardized readability tests and found that “the readability of all five was approximately equivalent to that of material intended for upper division undergraduates or graduate students. Four of the five forms were written at the level of a scientific journal, and the fifth at the level of a specialized academic magazine” (p. 900).

Reading a form does not ensure that the client understands the material or can remember it, even a short time later. Robinson and Merav (1976) re-interviewed 20 patients four to six months after they had read and signed a form for informed consent and had undergone treatment. They found that all patients showed poor recall regarding all aspects of the information covered by the form, including the diagnosis, potential complications, and alternate methods of management. Cassileth et al. (1980) found that only one day after reading and signing a form for informed consent, only 60% of the patients understood the purpose and nature of the procedures. A perfunctory indication from clients that they understand can be unreliable (Irwin et al., 1985). The clinician bears the responsibility for ensuring that the client understands the information

It would be comforting to believe that the identification of problems in these early studies led to effective solutions. Unfortunately, the problems have continued to emerge. For example, research by Akkad

et al. (2006; see also Armstrong et al., 2012; Commons et al., 2006; Dixon-Woods et al., 2006; Wallace et al., 2008) found that:

As suggested in previous work ... many thought the primary function of the form was to protect the hospital .... These findings are disconcerting for healthcare professionals and patients alike and raise questions about how far current consent processes genuinely fulfil their aim of safeguarding autonomy and protecting patients' rights (p. 529).

Similarly, Özhan et al. (2014) found that over half the patients surveyed in the study reported that they had not even read the form, citing a variety of reasons such as they found the form hard to understand, they did not have enough time, or they didn't have their glasses with them. In another study, Weckbach et al. (2016) gave patients a 10-item multiple-choice test to see if they understood the necessary information for the consent they had previously given. They found that less than a third were answered correctly, and concluded that the "patients' informed consent is barely based on knowledge" (p. 3). Finally, a more recent study by Lustgarten and colleagues (2017) found that the readability of informed consent documents at university counseling centers are challenging for college students to comprehend—reflecting similar results from earlier studies on the readability of informed consent forms (see also Ogloff & Otto, 1991).

Engaging effectively in the process of informed consent requires us to have sufficient knowledge regarding our ethical responsibilities as well as a deep respect for the rights and dignity of the patients we serve. The next section provides some scenarios that can help us think a little more about the complexities of the informed consent process.

# SCENARIOS FOR DISCUSSION

You work full time for a health maintenance organization (HMO) that requires the clinician to obtain written informed consent from all patients before providing therapy. One of the HMO physicians refers a patient to you for therapy. When the patient shows up for the initial session, you discover that the patient has recently been permanently blinded by an explosion and wants help in making the transition to living without reliance on this particular sense.

- How do you feel?
- What are the initial consent issues that you consider?
- In what ways, if at all, should the consent process explicitly address therapeutic approaches specifically developed for those without sight?
- If you were not fluent in Braille, the HMO provided no consent forms in Braille, and no HMO employee could write in Braille, how would you approach the HMO's requirement that written consent be obtained before clinical services were provided?
- If the patient asked if any of the interventions you planned to use had been validated as effective for those without sight, how would you respond?
- If the patient asked if your graduate training and supervised experience included adequate work with sightless patients so that you were competent to provide services to this population, how would you respond?

...

You work for a clinic that allows no more than eight sessions of outpatient therapy in any given year. A new client tells you during the first session that surprising and intrusive memories have started to occur about experiences of incest as a child. The client

thinks that the parent who perpetrated the incest may now be sexually abusing several grandchildren.

- How do you feel?
- What are the informed consent and informed refusal issues, if any, that you consider during this initial session regarding a formal assessment of this client?
- What are the informed consent and informed refusal issues, if any, that you consider during this initial session regarding potential clinical interventions for this person?

• • •

You have just begun working as a counselor at a university counseling center. At your first meeting with the counseling center director, you ask if the center has consent forms. The director replies, “I’m so glad you brought that up. We’ve been leaving that up to individual counselors, but we need one that everyone can use. I’ve been looking at your curriculum vitae, and I think you’re the perfect person to design the form. Please have it on my desk by next Thursday”.

- How do you feel?
- Assuming that there is no way you can get out of this task, what process would you use for designing the form?
- What issues or elements are you sure the informed consent form should address?

• • •

You have agreed to provide therapy to an adolescent who had gotten in trouble for drinking. The parents have agreed to allow the sessions to be confidential, given your ethical responsibilities. However, they now request to see the records because they have reason to believe that their adolescent is smoking pot.

- How do you feel?
- What are the legal and ethical factors you consider?
- What do you think you might say to the parents?

- What do you think you might say to your client?
- To what extent does your form for informed consent adequately address the issues that this scenario raises?

■ ■ ■

You work for a large healthcare company. Utilization reviews are required before additional sessions are provided. You realize, during the review, that although you believe sexual orientation is a critical issue and focus for your gay client, you did not inform your client that the information would be revealed to the reviewer.

- How do you feel?
- What consent issues does this situation involve?
- What possible approaches do you consider in deciding how to handle this situation?
- What information concerning utilization review, peer review, and similar review processes should an adequate form for informed consent and informed refusal contain?

■ ■ ■

You are engaging in the process of informed consent with a client who has been very quiet. She is looking at you attentively as you describe the process of therapy. She then states, “I really don’t want to be here, but they told me that you are the only one who can save me. Please, you are my only hope. I cannot take this anymore, tomorrow is my birthday, and I will have a party at the office where I live. Would you please cut my hair, it is so long, I cannot breath with it”.

- What are you thiking?
- How are you feeling in the moment?
- How would you proceed?
- What are your responsibilities in this case?

■ ■ ■



You work at an immigration detention center with unaccompanied minors. You know that all of the information that you write down about your clients can be used to determine the result of their petition for asylum. However, you also know that if you share this information with your clients during the informed consent process they will be afraid to share information that can be crucial to the development and delivery of an effective treatment plan. One of your clients, an 11 year-old boy of Guatemalan descent, whom according to his file has refused to eat or talk for several days, says to you “Dr. please help me, I really want to tell you about what is happening to me in this place, but you must promise me that you will not tell anyone”.

- How do you feel?
- What do you think?
- What are some of the consent challenges that working in this setting presents?
- How would you respond to your client?
- What would you do?

# **Chapter 17**

## **CREATING AND USING STRATEGIES FOR SELF-CARE**

The theme of personal responsibility runs through this book. We cannot escape responsibility for what we choose to say and do or for those times we choose to remain silent and do nothing. We cannot hand over this responsibility to an ethics code, the law, our colleagues, our government, our employer, an insurance company, a professional association, or any other source outside ourselves. Few of us can fulfill this responsibility if we are personally drained, overwhelmed, or demoralized.

We recommend creating strategies for self-care as early as possible in your education, training, and practice. “Promoting self-care during training is likely to provide a foundation for career sustaining self-care practices that prevent burnout in later professional life” (Pakenham, 2015, p. 145). Neglecting an ethic of self-care early on can drain the enthusiasm, joy, resilience, and meaning out of a career. It can undermine our competence and hurt our ability to practice ethically. It can sink us in discouragement, compassion fatigue, and burnout.

### **PAYING ATTENTION TO THE SELF**

Psychotherapy is demanding work. It can leave us physically, emotionally, and spiritually drained. Even doing related tasks while not doing psychotherapy—writing chart notes, requesting authorizations and prior approvals, billing insurance companies, returning phone calls between sessions, sending a second bill to insurance companies after receiving notification that they never received the first bill we sent, filling out disability claim forms, sitting on hold while waiting to ask the insurance company why it is now saying that we used the wrong code on the second bill we sent when

that is exactly the code it told us to use when we called before sending in the first bill, trying to figure out why the microphone suddenly goes silent during Zoom therapy sessions, and trying to find time to consult about a suicidal patient who does not seem to be responding to therapy—can run us ragged.

In the midst of these demands, paying attention to the self is crucial. An occupational hazard that trips up too many of us is failing to stop and pay attention when we become too exhausted, too discouraged, too frustrated, too sad, too angry, too disillusioned, or too cynical. We try to plow ahead, pushing aside the awareness that we are hurting. Instead of trying to understand and do something about what's gone wrong in our lives, we try to ignore it. Or explain it away. Or self-medicate. Or assume there is nothing we can do.

Good strategies for self-care include reminders to stop and ask ourselves if we are hurting and, if we are, to ask ourselves why and what we can do about it. Actively looking for red flags that we may not be taking good care of ourselves can be helpful. The next section discusses a few of these red flags.

## **WHAT HAPPENS WHEN SELF-CARE IS NEGLECTED**

Neglecting self-care can have corrosive consequences for the therapist and therapy. Every psychologist is unique in important ways, does work that is unique in important ways, and experiences the effects of neglecting self-care in a personal way. Yet some common themes appear. Each of the following may be a result of, aggravated by, or a reflection of neglecting self-care, though each, of course, can have other causes.

### **Disrespecting Clients**

When work is overwhelming, therapists may fail to treat their clients with dignity and respect (see [Chapter 4](#)), talking about them in ways that are disparaging, degrading, and belittling. They may complain about how unmotivated, ungrateful, selfish, insensitive, dishonest, lazy, and generally undesirable their clients are. They may grow

harsh, judgmental, and rejecting. They may lose empathy, kindness, and connection. They may distance and dehumanize their clients, referring to them only by labels. They may tell jokes about their clients, invent demeaning nicknames for them, and ridicule them in other ways.

## **Disrespecting Work**

Depleted and discouraged through lack of self-care, therapists may trivialize or ridicule their work. They may call therapy a charade, fraud, or joke. They may view their work as empty, ineffective, and meaningless. They may start showing up late for sessions, skip some scheduled sessions altogether, or fail to return clients' telephone calls.

## **Making More Mistakes**

Despite our best efforts, we all make mistakes. Openly admitting our mistakes and correcting them or addressing the problems they cause is one of our ethical responsibilities as therapists. But self-neglect can hurt our ability to do our work. We may begin making more and more mistakes. We find ourselves accidentally double-booking clients, forgetting appointments, calling a client by the wrong name, misplacing charts, or locking ourselves out of our own office.

## **Lacking Energy**

If we do not take care of ourselves, we can run out of energy and find ourselves without sources of rest and renewal. We wake up tired, barely find the will to drag ourselves out of bed and to work, fight to stay awake during a session, wonder how we will ever make it through the rest of the day, leave work—*finally!*—too exhausted to do anything fun, and head to bed only to start the grim and grinding routine all over again.

## **Becoming Anxious and Afraid**

If we fail to care for ourselves, we may fall victim to fear and anxiety. We begin to doubt that we are up to dealing with the uncertainties, challenges, demands, and stresses of practice. What if our referral

sources all dry up and our current clients terminate? Did we bungle that last assessment, wind up with the wrong diagnosis, and miss crucial aspects? Did we say the wrong thing when responding to a suicidal crisis, and will that person commit suicide before the next session? What if that agitated client becomes violent during a session? What if someone files a malpractice suit?

## **Using Work to Block Out Unhappiness, Pain, and Discontent**

If we neglect our self-care and our lives lack joy, meaning, and fulfillment, one self-defeating response is to try to lose ourselves and our painful feelings in work—wall-to-wall work. More and more clients, projects, and responsibilities crowd our lives until we lack free time to reflect on our lives, spend time alone apart from work, or face how lost, empty, anxious, afraid, or hopeless we are. Some therapists work long hours and revel in it, finding great joy and fulfillment, but the pattern here is different. Filling the time with work brings little to nourish the self—it only distracts us from an unfulfilling life. Excessive work is only one of the destructive coping strategies (others are abusing food, alcohol, and drugs) that we use to block out what happens when self-care is neglected.

## **Losing Interest**

Neglecting self-care can lead to an empty professional life that no longer brings excitement, joy, growth, meaning, and fulfillment, and as a result, we may lose interest in it. We no longer feel committed to the work or connected to our clients. We go numb and try to get by on automatic pilot. We go through the motions, forcing ourselves to do as good a job as we can. Our heart is no longer in it.

## **MAKING SURE THE STRATEGIES FIT**

A good fit is as important in self-care strategies as it is in clothes. Making or buying clothes that fit our friends, or that fit the “average” person, or that match the most popular sizes won’t help most of us find clothes that fit well. Using self-care strategies that are lifesavers for our colleagues may make us miserable. What sustains,

replenishes, and gives us meaning as individuals may flow far from the mainstream. Few of us would tell someone who has found happiness, significance, and contentment in choosing a solitary monastic life with vows of silence and poverty, “You know, you really ought to get out and socialize more and find ways to earn some money so that you’ll have a nest egg you could rely on. I know you’d feel better about yourself and have a better life! It’s worked for me and so many others!”

Listening to ourselves, experimenting, being honest with ourselves about what does and does not work are part of creating self-care strategies that fit us as individuals. Although there is no one-size-fits-all to any self-care strategy, here are a few of the challenging areas that many therapists contend with in making sure that they are taking good care of themselves.

## **Isolation vs. Connection**

Solo practice can isolate us. We spend our days in our office. Especially if we work long hours, we can lose touch with friends, colleagues, and the world beyond our office. Even during “free” time when no patient is scheduled, there are always charts to update, bills to prepare, work-related telephone calls to make, and so on. Some therapists find it helpful to place strict limits on the time they spend in the office and schedule activities that bring them out of isolation. Creating ways to stay connected to others is a basic self-care strategy for many therapists.

## **Monotony vs. Variety**

Even when we limit our time with clients to, say, 30 to 35 hours a week, spending so much time seeing clients can be too much for some therapists. Some find work to break up their days and provide variety like teaching a course, consulting, leading a supervision group, getting active in local, state, regional, or national professional organizations.

## **Fatigue vs. Limits, Rest, and Renewal**

How much time do you need between clients: 5, 10, or 15 minutes? How many clients can you see in a row without needing a longer break of at least an hour or more? How many clients can you see in the course of a day without feeling so tired that the quality of your work falls off as the day goes on? Therapists differ greatly in these areas. Some work four consecutive 50-minute sessions with a 10-minute break between each, take an hour off for lunch, and return for another four consecutive sessions without any lapse in enthusiasm or competence. Others can do their best work with no more than five clients each day. Knowing and respecting our personal limits is a key aspect of self-care. Some consider 25 to 30 client-hours a week to be full time because of the additional hours needed to keep clinical records, return telephone calls, and so on.

Part of self-care in this area is learning what workload we can handle well and creating a schedule that matches that workload. The focus must remain on the amount of work that we can do well, not the amount that we feel we should do, or used to be able to do, or that some of our colleagues do. Sometimes the top number of hours that we can do good work with clients conflicts with the number of hours we need to do therapy in order to pay the bills, develop our practice, or please our employer.

Effective self-care strategies not only influence our patterns of breaks—everything from the breaks we take between sessions to our vacations—but also emphasize activities, attitudes, and approaches that help us recover from fatigue, that replenish and renew us on a daily basis.

## **The Sedentary Life vs. Physical Activity and Exercise**

Psychological assessment and therapy are usually—not always—done while the client is sitting (or lying down) and the clinician is sitting, neither of them moving around much. For many therapists, self-care includes making time for moving, stretching, and physical exercise. Physical exercise is a major self-care strategy for many therapists, not only for its physical benefits and the break it provides from work, but also for its psychological benefits (see, e.g., Chan et al., 2019; Ensari et al., 2015; Gaitan-Sierra & Hyland, 2014; Hays, 2002;

Klaperski et al., 2019; Lefferts et al., 2019; Ludyga et al., 2020; Morres et al., 2019; Rebar et al., 2015; Wang et al., 2014).

## **The Dispirited Life vs. Nurturing the Spirit**

If a psychology practice does not provide us with enough physical movement and exercise, it may also fail to nurture the life of the spirit. Setting aside time for meditation, prayer, and other spiritual or religious practices can be an important aspect of self-care for some therapists. Others find that such diverse activities as reading or writing poetry, hiking through the woods, playing or listening to music, sitting on a riverbank, acting in or viewing a play, or watching a sunset helps nourish their spiritual lives. For many, these experiences often bring a sense of awe, peace, joy, and transcendence.

## **The Unsupported Life vs. Support Networks**

Graduate schools and internships place us in a network of professors, supervisors, administrators, and other students. Facing a challenge, we can talk it over with teachers and classmates. Our clinical work is closely monitored, and we receive feedback, ideas, suggestions, and guidance. When we start an independent practice or begin work in an agency that tends to be unsupportive and isolating, the responsibility to create that support network falls to us. What are some important components of a support network? This is not an exhaustive list but here are 10 important components:

### ***1) Supervision, Consultation, and Additional Training***

Find or create resources for talking over your work, expanding your knowledge and skills, and continuing to grow as a psychologist. Is there someone you would like to hire to provide you with supervision or consultation? Understanding how *supervision* and *consultation* are defined under state laws and regulations is crucial. They tend to differ in terms of who is primarily responsible for clinical care and decision-making. Would you like to create a peer-consultation



group? What continuing education courses, workshops, and other activities would help you update your knowledge, improve your skills, and expand your areas of competence? What local, state, national, or international organizations could provide you with information and support? Consider what sources of support you as a unique individual will need to practice effectively.

## **2) Accountant**

Find an accountant you trust to help review your business plans, look at your current financial resources, and advise you on tax matters. They will be able to discuss issues such as the pros and cons of incorporation, what expenses will be deductible, which records and receipts you'll need to keep for tax purposes and compare the relative financial merits of a home office, a separate office shared with one or more clinicians, or a separate office for you alone.

## **3) Billing/Bookkeeper**

Many practitioners do their own billing and bookkeeping. If you choose this route, you might look into software programs that can help with these tasks. Other clinicians prefer not to take on this additional administrative task. Instead, they hire an individual or company to do their bookkeeping and billing. Some communities have services that specialize in this area for psychotherapists or for health-care providers more generally. Check with colleagues in your community for recommendations.

## **4) Psychopharmacology Resources**

Unless you are able to prescribe medications, find someone skilled in psychopharmacology who will work collaboratively with you and your patients. Some patients, of course, do not need psychotropic medications, and others may come to you already taking medications prescribed by someone else. You may wish to refer some patients to a psychopharmacologist with prescription authority for an evaluation to see if medications might be helpful.

## ***5) Emergency, Hospital, Safety, Legal, and Other Resources***

What are the emergency, inpatient, and day treatment settings, homeless shelters, interpersonal violence shelters, food banks, legal aid, immigration, asylum, and similar services available in your community? How much do they cost, and what are their admission criteria? Visit them, and introduce yourself to the staff and administration. Find out about their policies and procedures. For hospitals, find out whether you are eligible for staff privileges. If one of your clients needs hospitalization or other crisis services, you will be familiar with available options and the necessary steps for each.

## ***6) Mandatory and Discretionary Reporting Resources***

Find the contact information for the agencies to which you would file mandatory or discretionary reports of such matters as suspected child abuse or elder abuse. There may be times when you are unsure of whether you are obligated to file a report. One source of consultation you can draw on at such times is the agency to which you would file the report. You can call and, without disclosing any identifying information about the actual people involved, provide the agency with a hypothetical situation and ask if such a fact pattern falls under the duty to report. Be sure to document that consultation as one of the steps you took to decide whether to report. You may also call your attorney, your licensing board, or your professional liability carrier for guidance.

## ***7) Attorney***

We recommend finding an attorney experienced in mental health issues in your jurisdiction as early as possible in your career. He or she can review your forms, policies, and procedures; answer your questions about legal requirements and pitfalls; and be a telephone call away if you are in the midst of responding to an urgent situation and need legal advice. Some state or provincial psychological

associations may offer an attorney consultant as part of the membership services.

## ***8) Personal Relationships***

Good relationships can be key to our sense of well-being. An absence of good friends (and the time to spend with them) or spending too much time in toxic relationships can lead to burnout. Feminist Jean Baker Miller (1988, 1991) described the qualities and dynamics of relationships that make us feel understood, valued, and more alive. Judy Jordon (1997) emphasized the importance of a sense of connection. “Ruptures” in our important personal or work relationships can be devastating. Seymour Sarason (1974) looked at the social environment that we find or create for ourselves and emphasized the “psychological sense of community,” (p.157) that feeling that one is part of a larger dependable and stable structure (see also Nistor et al., 2015; Ray et al., 2019).

## ***9) Maintaining Health***

Moving from a graduate school environment that often includes a student health service and health coverage to suddenly being out on our own in independent practice or in organizational employment that offers little or no health coverage makes it easy to neglect our health and medical needs. It becomes our responsibility to find affordable health-care coverage well matched to our individual needs and a competent physician whom we trust. Colleagues and local insurance brokers may be good sources of information.

## ***10) Managing Stress***

Therapists may experience periods of extreme unhappiness and distress. Some of the themes in [Chapter 6](#): Competence, Humility, and the Human Therapist, are worth reviewing here. In one national study of therapists’ accounts of their own experiences as therapy patients (Pope & Tabachnick, 1994), of the 84% of the therapists who had been in therapy, 61% reported experiencing at least one episode

of what they termed clinical depression, 29% reported having felt suicidal, and 4% reported having attempted suicide.

Practice itself may be stressful. In another national study of practicing therapists (Pope & Tabachnick, 1993), 97% reported fearing that a client would commit suicide, 91% reported fearing that a client would get worse, 89% reported fearing that client would attack a third party, 88% reported fearing that colleagues would be critical of their work with a patient, 86% reported fearing that a client would need clinical resources that are unavailable, 83% reported fearing being attacked by a patient, and 18% reported having been attacked by a patient. Over half reported having been so afraid about a client that it affected their eating, sleeping, or concentration. About 12% reported that a client had filed a formal complaint (e.g., about malpractice or licensing) against them. Over 3% had obtained a weapon to protect themselves from a patient.

Anger was another major theme of the study. For example, 83% reported anger at a client because of unpaid bills, 81% reported anger at a client who was verbally abusive at them, and 46% reported having become so angry at a patient that they did something that they later regretted.

Effective self-care strategies take realistic account of both how stressful doing therapy can be and how distressed we can become. What resources can we develop for coping with the stresses of our work? How can we address our own distress, seek professional help if we need it, and become aware if we reach a point of being too distressed or impaired to work effectively? Our own personal psychotherapy can play a key role for many of us. Norcross (2005) noted that for therapists “The prevalence of personal therapy varies systematically with theoretical orientation. Psychoanalytic clinicians have the highest rates (82% to 100%) and behavior therapists the lowest (44% to 66%) in the United States” (p. 841). Orlinsky et al. (2011), in a study of personal psychotherapy among psychologists, counselors, social workers, psychiatrists, and nurses in six countries, found that “87% of the overall sample embarked on personal therapy at least once: 94% of analytic/psychodynamic therapists, 91% of humanistic therapists, 73% of cognitive-behavioral therapists, 82% of the novice therapists to 89% of senior therapists” (p. 828). For

some, personal therapy is not only a resource for dealing with stress and problems but a key part of training and professional development (Bennett-Levy, 2019; Råbu et al., 2019).

## **11) Self-Care Strategies for BIPOC<sup>1</sup>**

For Black, Indigenous, and People of Color (BIPOC), self-care also requires an understanding of how oppression impacts the self and creating ways to actively resist internalizing negative and inhumane messages about you and your community. The following list is not exhaustive but are some self-care ideas for you to consider:

- As a BIPOC, a form of self-care is to connect with individuals, communities, and organizations that affirm your humanity.

Having a healthy cultural suspicion or cultural mistrust (having a guarded stance toward individuals and institutions until they have earned your trust, taking time to build relationships with new colleagues) is considered a psychological strength for BIPOC (see Adames & Chavez-Dueñas, 2017; Boyd-Franklin, 2006; Whaley, 2001; White & Cones, 1999). Cultural mistrust can be considered as a form of self-care since it has allowed BIPOC to survive and thrive during times of stress throughout history.

- Systemic oppression may make many BIPOC believe that they must constantly work in order to prove their self-worth. However, making time for joy and pleasurable activities in and of itself is an act of liberation which can lead to a life that is fulfilling. As Audre Lorde reminds us, “Caring for myself is not self-indulgence, it is self-preservation” (1988, location 1702).
- There are times when the impact of racism and institutional oppression may lead you to feel overwhelmed and exhausted. During those times self-care includes giving yourself permission to experience what injustice naturally evokes in you. All feelings are acceptable including anger. Honor your feelings and remember that productive anger has led to positive change for BIPOC.
- The ultimate act of self-care for BIPOC is to resist internalizing oppression by knowing that the system does not get to determine

your worth, dignity, and humanity. You are inherently valuable and your life matters.

## **THE NEED FOR CHANGE**

Self-care strategies that support, strengthen, deepen, replenish, and enliven may, less than a year later, become a senseless obligation, distraction, and waste of time. Therapists who focus on the subtle, sweeping, and profound changes in their clients' lives can overlook changes in their own lives and how these changes can affect self-care needs and strategies. Effective self-care includes paying attention to the ways in which our needs for self-care can change over time, calling us to change course and create new strategies.

### **Notes**

- <sup>1</sup> This list is adapted from “Surviving and Resisting Hate: A Toolkit for People of Color” by Hector Y. Adames and Nayeli Y. Chavez-Dueñas (2017). [© copyright Adames & Chavez-Dueñas]. It is available online at [www.icrace.org](http://www.icrace.org)

# Chapter 18

## CREATING A PROFESSIONAL WILL

Creating a professional will fulfills an ethical—and in some places legal—responsibility for therapists and counselors. In the professional will, we provide a plan for what happens if we suddenly die or become incapacitated. It ensures that there is someone ready to respond to our clients' needs and the unfinished business of our practice. It gives them the information and authorization they need to navigate a time of shock, loss, confusion, and mourning. Not having a will in place puts us at risk of stranding our patients and colleagues, leaving them without access to vital records, schedules, contact information, and resources when our absence has stunned them with its suddenness.

The theme of therapists as vulnerable runs throughout this book. We therapists share many vulnerabilities. We can't wall ourselves off from the unexpected. A drunk driver, stroke, mugger, heart attack, fire, plane crash, and countless other jolts can strike us down without warning. As professionals whose services are critical to our clients, we bear an ethical responsibility to take the vulnerabilities that come with being human into account in our planning.

The best time to create a professional will is now rather than later. Yes, right now. Even with the best of planning and consultation, we cannot schedule the catastrophes that can suddenly take us out of action for a while or longer so that they will happen only at the end of our careers, or—better yet—long, long after retirement.

We must prepare for the possibility that something can happen to us—robbing us of our ability to function—at any time, with no warning. And if we decide “not now,” making it take its place at the end that line of all those things we'll take care of when we get a little free time, it may spend its whole life (and ours) growing old in that well-

meaning to-do list. And if something happens to us in the meantime and we don't have a will, we are leaving our patients and colleagues stranded.

There is no standardized, one-size-fits-all approach to creating a professional will that will work with every therapist or situation. Below we provide you with some steps that may be helpful in thinking through the process of creating a professional will that fit your individual needs, setting, practice, values, and resources.

## **WHO TAKES CHARGE?**

Who will respond effectively to the needs of your clients in the event that you suddenly die or are incapacitated? Who can take care of things in a time of great stress and uncertainty? Who would do it with sensitivity and understanding that is required to navigate all the moving parts? Who would take care of the details, making sure nothing is overlooked? Who is the best person to talk with your clients?

A good and effective professional will name a qualified executor to carry out the will. It also answers the following four questions: (1) How can the executor be reached if your professional will suddenly becomes active? (2) What are their best contact numbers? (3) What are their office and email addresses? (4) Are there other people who will know where the executor is if they prove hard to reach?

## **WHO SERVES AS BACKUP?**

Life loves surprises and sometimes refuses to cooperate with our plans. When it's time to step up and take charge, the executor may be presenting a paper at a conference half a world away, struggling to handle a family emergency, recovering from a stroke, or otherwise unavailable. Second and third designees need to be ready to step in if needed. Yes, we need a plan A, B, and C.

## **COORDINATED PLANNING**



Coordinated planning allows executors to carry out each step much more efficiently. You can meet with your primary designee and both backups to go over what needs to be done and provide the needed information. Someone may think of something that the others have overlooked.

What you may think “that goes without saying” or “You all know that bookshelf where I keep my appointment book, don’t you?” may actually need to be explicitly said. If designees don’t understand where something is, you can show them. You can introduce them to the people they will need to work with (e.g., your secretary, the executor of your personal will, your accountant, your attorney, your office landlord). They can exchange contact information with each other.

When wills are carefully planned, clearly outlined, and detailed, the executor will understand what to do when the time comes to carry out the professional will. You’ve left them a road map and the executor will know the key people to contact, where your records are, and so on.

## **YOUR OFFICE, ITS KEY, AND ITS SECURITY**

The will should provide the *specific* location of each key to your office—for example, “There are four copies of the key to my office. One is on the key ring that I always carry with me. It is the key with the blue plastic on it. My partner, whose contact information is ..., also has a key to the office. My secretary, whose contact information is ... has a key. The building manager, who can be contacted in an emergency at ... has a key.”

Don’t forget any separate keys for each of the consulting room doors, the storage room, the filing cabinets, the desks, the computer, and the door to the building itself. Some of these may be easy to overlook but essential. If your office security systems require a code, be sure to supply both the necessary codes, instructions, and the system’s location.

## **YOUR SCHEDULE**

We plan and then life happens. Several key considerations are important to consider when you plan to give the executor access to your schedule. Where is your schedule kept? Do you use a daily planner you keep with you, an appointment book at the office, on your computer or personal digital assistant? Once the record of your scheduled appointments is located, is additional information needed to access it? For example, if you keep your schedule on your computer, what passwords are used to log on and access the schedule, where on the drive is the schedule kept, what are the names of the relevant files, and is there a backup somewhere if the copy on your computer has become corrupted or if the computer itself is unavailable (e.g., destroyed in an office fire or earthquake or stolen)? Is the material on your computer encrypted and subject to two-factor authentication? What is the password to the two-factor authentication? Where will the two-factor authentication go? Your cell phone, an alternative email, both?

## **CLIENT RECORDS AND CONTACT INFORMATION**

A useful professional will includes clear instructions about how to find and access client records and contact information. The ability to locate treatment records promptly may be critical because the sudden loss of a therapist may trigger a crisis for some clients. The executor (or someone appointed by the executor) may need to contact your clients quickly. Because some clients may not have told their family members that they are seeking care, the process of notification may be complicated. Make it clear in your professional will whether you have a place in your files indicating how clients prefer to be contacted. The professional will should also designate whether the executor or someone else will maintain the client records of the incapacitated or deceased therapist. This information can be announced via local newspapers, your voicemail or answering service, your website, a notice at your office, information filed with the state psychology licensing board and state psychological association, or all these methods.

## **AVENUES OF COMMUNICATION FOR CLIENTS AND COLLEAGUES**

How do clients and colleagues contact you—answering machine, e-mail, other methods? Clearly describe each and how the person carrying out your professional will can access the messages. What codes are used to retrieve messages from your answering machine? Do you have a website for your practice? Do you have any social media accounts (e.g., Twitter, Facebook, Instagram, Clubhouse)? How can this be accessed? What are the names of any relevant e-mail accounts along with the user name, password, server address for receiving and sending mail, and so on?

## **NEW MESSAGES FOR YOUR ANSWERING MACHINE, EMAIL ACCOUNT, ETC**

The prior step made sure the executor can retrieve messages from your answering machine, e-mail account, and so on. But what kinds of outgoing messages, if any, are appropriate for these different channels of communication? What recorded message should callers hear when they reach your answering machine? Should an auto-response be set up for your e-mail account? There are no easy answers to these questions, but you will likely know best what is most appropriate for your particular practice.

## **INFORMED CONSENT**

Clients have a right to give or withhold informed consent for release of information. Documentation of consent for providing the executor with client contact information and access to client charts can be kept with the client charts and a note of it made in the professional will. One option is to include the name(s) of the executor in the original description of services that patients read and sign as part of informed consent. In other words, it would be helpful to include a statement indicating that you have designated a colleague as your professional executor in the case of death or disability to have access to the client's records, to provide psychological services if needed, or to refer to another qualified professional if needed.

## CLIENT NOTIFICATION

Therapists may choose one or more methods to notify clients of a therapist's incapacitation or death, such as calling each client, placing a notice in the local newspaper, placing a message on the practice's website changing the outgoing message on the answering machine to include the announcement, changing the answering machine message to ask clients to call the clinician who is implementing the deceased therapist's professional will, and sending letters. It is worth spending some time considering the potential impact of each method and considering it in terms of the Golden Rule: Would any of us want to learn of our own therapist's or clinical supervisor's death by reading about it in the newspaper or hearing a recorded announcement on an answering machine? —and of how each of our current and former clients might respond.

Are there resources that clients might find helpful in these circumstances (e.g., designated colleagues who will make appointments available to your clients to help them deal with the immediate consequences and, if the clients choose, to locate subsequent therapists)? You will have a good sense of which approaches will work best for your individual practice and the relationship you have with your clients. Some long-term patients may require special consideration. Religious, cultural, and racial issues may be key for some patients.

The notification method must respect each client's right to privacy. Letters and phone messages that are not carefully handled can lead unintentionally to the disclosure to third parties that a person is seeing a therapist. Family members and others may not always respect the privacy of someone's mail and may, perhaps "accidentally," open and read mail that is not addressed to them. A telephone message left on an answering machine sometimes can be heard by those for whom it was not intended. In some cases, such unintentional disclosures can place a client at great risk. The abusive partner, for example, of a battered client may become enraged at finding out, through an intercepted letter or telephone message, that the client has sought help and may react violently, perhaps lethally.

## **COLLEAGUE NOTIFICATION**

Who else in your professional life that would you like to be notified? What colleagues should be notified immediately? Are you a member of a group practice, or do you share a suite of offices? Are there clinicians who provide consultation or supervision to you on a regular basis or who receive those services from you? Do you co-lead a therapy group or family sessions with anyone? Are there conferences or workshops where you are regularly present? It can be helpful to check the listings in your scheduling book for a few months to make sure that you do not overlook any colleagues who should be listed (along with contact information) in your professional will for immediate notification.

## **PROFESSIONAL LIABILITY COVERAGE**

Make sure your executor knows the name of the company providing professional liability coverage, contact information, the policy number, and instructions for the company to be notified immediately on the therapist's death or incapacitation. Include the username and password for remote access to your professional liability coverage.

## **ATTORNEY FOR PROFESSIONAL ISSUES**

Many therapists consult an attorney for professional issues. You may have arranged for an attorney to review your office forms (e.g., informed consent, release of information) to ensure that they conform to state legislation and case law requirements. You may have discussed with your attorney your policies and procedures, format for keeping records, or particularly troublesome cases that raised puzzling legal questions. You may have sought legal consultation about how to respond to a subpoena or legal representation in a malpractice suit. Your executor is likely to find it helpful to know the name and contact information for any attorney you've consulted. The attorney you consult for professional issues may also help you in creating a professional will.

## **BILLING RECORDS, PROCEDURES, AND INSTRUCTIONS**

Your executor will need to know where the billing records are, how to access them (e.g., if they are maintained by computer software), who prepares and processes the bills (e.g., a billing service, accountant, or office clerical worker), and how pending charges are to be handled. Describing how any pending bills will be handled (e.g., office rent, utilities, website fees).

Some therapists may wish to forgive part or all of any remaining unpaid bills that were to be paid out of their clients' own pockets. Some may wish to provide a session—at the deceased therapist's expense—for each client, during which the clinician serving as executor of the professional will work with the client to discuss the situation, assess current needs, and explore options for future therapy. The professional will should include explicit instructions about any such wishes.

## **EXPENSES**

How have you and your designated executor and back-up executors decided on the executor's compensation? Perhaps the easiest arrangement is at the executor's customary hourly rate, but other approaches can be used—for example, a flat fee, an honorarium payment, the executor declining any compensation for rendering this service to a friend, or a contribution to a charity chosen by the executor.

A professional will needs to include clear instructions about how all business-related expenses are to be paid.

## **YOUR PERSONAL WILL**

Reviewing both your professional will and your personal will side by side to spot any inconsistencies can head off unintended problems and conflicts. If a personal will, for example, directs all assets to be disbursed in a certain way but makes no mention of funds to be used

to pay the executor of your professional will, problems can arise. It is useful if each will make explicit reference to the other.

## **LEGAL REVIEW**

A careful review of the professional will by an attorney skilled and experienced in mental health law can prevent numerous problems. The executor of the professional will can consult with the attorney about any legal questions arising in the days, weeks, and months after the therapist's death.

The attorney can advise on whether, in the light of state legislation and case law, the professional will is best authenticated simply by the signatures of disinterested witnesses, the seal of a notary, or other means.

## **COPIES OF THE PROFESSIONAL WILL**

Give copies of your professional will to those designated as potential executors and to your attorney. Some therapists may consider making special arrangements to ensure the executor gains access to information such as their passwords for retrieving e-mail and answering machine messages only after their death. These arrangements avoid having confidential information in multiple copies of the will distributed to others.

## **REVIEW AND UPDATE**

People, practices, situations, and times change. The passage of a year or two may turn a professional will that is perfectly suited to us when we draw it up into a storehouse of out-of-date instructions and misinformation. It is helpful to review a professional will on a regular basis—say, once a year—and make an immediate update whenever there is a significant change in our circumstances.

# Chapter 19

## **RESPONDING TO ETHICS, LICENSING, OR MALPRACTICE COMPLAINTS**

Getting hit with a malpractice suit can feel like falling into a Kafka nightmare where we—our judgment, our actions—are always on trial. A nightmare of skilled plaintiff attorneys focusing on our faults, pouring over our chart notes to find evidence against us in what we did or failed to do, gathering testimony that we harmed someone. A nightmare world of interrogatories, depositions, delays, planning, meetings with attorneys, worry, and what-ifs that robs from us the time we once spent with patients, friends, and family. Confidence can shake and shatter. Reputation can rattle and crumble into ruins. Complaints to licensing boards and ethics committees can wreak the same havoc.

Unfortunately, the possibility of experiencing this Kafkaesque scenario is a real one in the work that we do. Being prepared and knowing what to do and how best to proceed is paramount. Stunned, the unprepared therapist can rush to respond, turning a bad situation into a catastrophe. Preparation helps us take informed, thoughtful, effective steps and make informed decisions as we move along this stressful process. Preparation also helps us to view the possibility of a formal complaint realistically.

Anxiety about being sued can grow into terror, rumination, or an obsession. A single-minded, intense, fearful struggle to avoid any risk of a lawsuit can blot out the reasons we got into this line of work to begin with—that is to help people, earn money to support ourselves and our loved ones, do meaningful, fulfilling work that we enjoy and are good at. We change our primary occupation from therapist to risk manager.



Intelligent risk management is part of good practice, but that is all it is: a part and not the sum. Once we start living and working in fear of a complaint and allow that fear to dominate all decisions, something vital goes missing.

To help prevent our lives and practice from being consumed by the fear of being sued, we recommend being prepared for this possibility early. We consider the planning as part of an approach to ethics and therapy. Below we provide some considerations you may find helpful to prepare for responding to a formal complaint.

## **DON'T PANIC**

Okay, go ahead and panic a little if you can't help it or believe that if you don't show some panic then your psychologist friends will accuse you of "being in denial." Then take some deep breaths, pull yourself together, and do whatever you need to do to think clearly. It is okay to feel whatever it is you are feeling at the moment, but it is important to avoid letting panic, fear, or any other strong emotion hijack you and drive your decisions.

## **CONSULT YOUR ATTORNEY *FIRST* —AND MAKE SURE YOU HAVE A GOOD ONE!**

Many therapists forget this step or try to save time and money by ignoring it. Opening an envelope to discover a licensing complaint, some clinicians figure that this minor misunderstanding can be resolved quickly by sending an explanation along with supporting documents. Receiving notice of a malpractice suit, other therapists hope that inviting the client to come in for a free session to discuss it "without all these lawyers" is the best way to reach a positive resolution and convince the client that there really was no reason to file a suit.

Unfortunately, responding to formal complaints before consulting an attorney can lead to disasters. The therapist is moving into a different realm. An attorney can help guide us through the minefields of formal complaints that may be invisible to us. Good malpractice attorneys work in the world of complex legislation, case

law, and court customs governing malpractice actions and some specialize in defending mental health professionals against licensing board complaints. Attorneys experienced in licensing and ethics hearings know the norms and customs. They can interpret the rules and procedures.

Good attorneys bring not only specialized knowledge and experience. They also bring another perspective since the attorney is not the object of the complaint. As the old aphorism has it, the person who represents themselves has a fool for a client.

Attorneys point out the pitfalls of strategies that may otherwise seem to make perfect sense. A psychologist who has not consulted an attorney may talk to colleagues about the case, talk to the opposing attorney, write letters to various people mentioning the case, or blow off steam about the case within earshot of others and discover only later that these spoken and written statements and outpourings, which are not privileged, become key evidence that could be used against them.

Attorneys may give strong advice—sometimes a stern list of dos and don'ts. But a good part of what an attorney does is lay out options. For example, attorneys can tell us whether we can discuss the case with a supervisor, a consultant, a colleague, a friend, a family member, or anyone else and have what we say remain confidential and privileged. Attorneys can also explain the effects and implications of turning down a settlement offer from the plaintiff in a malpractice suit.

Since so much can depend on your attorney's knowledge, skill, experience, trustworthiness, and dedication, make sure you have a good one. It is stunning how many therapists spend much more time researching a new computer, car, or refrigerator than a new attorney. They may talk with several carpenters or contractors before hiring one to do work on their home but hire an attorney without taking a look at the attorney's qualifications, experience, and record, or considering alternatives. Ask colleagues about their experiences and recommendations. How many cases like yours has the attorney handled? What were the outcomes? How available are they? Will the attorney you are considering handle the case personally, or will a junior associate take over once you commit? If you are a Black,

Indigenous, Person of Color, a member of the lesbian, gay, bisexual, transgender, queer (LGBTQ) community, a religious minority, and the like—does the attorney have any experience and knowledge about biases and their implications for cases like yours?

## **NOTIFY YOUR PROFESSIONAL LIABILITY CARRIER**

A professional liability policy may include a requirement to notify the company immediately not only if you are sued but also if you have reason to believe that you may be sued. But requirements aside, it makes sense to let the carrier know if you become aware of a possible or actual formal complaint. The carrier may give you helpful guidance and provide you with an attorney. Some liability insurance companies offer financial coverage of legal representation for licensing complaints, if you have chosen that option upon obtaining or renewing your policy.

## **WHO IS YOUR ATTORNEY'S CLIENT?**

The answer seems obvious: You are! But if the insurance company pays the attorney, are the insurance carrier's interests and your interests the same? What if the insurance company approves only a very limited discovery, hoping to hold down expenses? What if the carrier believes it makes sense financially (i.e., it is in the carrier's financial interests) to settle a case that you believe is bogus and would be decided in your favor were it vigorously defended? Settling the case, which would likely become a matter of public record, could have negative influence on your career, particularly if you often testify as an expert witness. In some rare circumstances, if you (or you and the attorney) are unable to persuade the carrier to litigate rather than settle the case or to provide an adequate discovery and vigorous defense, you might consider hiring a separate attorney with your own funds to press your claims with the carrier.

## **IS THE COMPLAINT VALID?**

When someone files a formal complaint against us, it is natural to feel hurt and attacked. Malpractice trials can fan the fires of anger on both sides. Before that process goes too far, ask yourself: Did you actually do what someone has accused you of doing? Setting aside defensiveness, rationalization, counterattacks, and the fact that the charges may be overstated and wrong in the details, is there *any* truth to the claim that you did something you should not have done or that you failed to do something that you should have done?

Being relentlessly honest under these circumstances is anything but easy. Acknowledging that you may have done something wrong, even if not intentional, may seem self-destructive, indulging a tendency to beat yourself up when you need all your survival skills to rescue your reputation and career. But holding tight to the reality of what happened—avoiding memory’s revisionism—can help us to respond effectively to the complaint and survive the ordeal in a way that is the very opposite of self-destructive.

## **DID YOU MAKE A FORMAL COMPLAINT MORE LIKELY?**

It is worth asking: Regardless of whether you did or did not do what you are accused of doing, did you somehow make the complaint more likely? For example, did you make a normal, run-of-the-mill human error—not something illegal or unethical but just a mistake—and, when given a chance, refuse to acknowledge it or say you were sorry? Was there a misunderstanding—perhaps a client mistakenly thought you had done something wrong—that you refused to clarify? In other words, as you think through what happened with the benefit of hindsight, did your attitude or behavior increase the chances that this complaint would be filed?

In our experience, many (but by no means all) formal complaints seem to have less to do with a therapist doing something unethical than with the therapist–client relationship. The therapist has come across to the client as lacking respect, caring, and a reasonable ability to listen. Therapists who communicate these positive qualities to clients often seem to make all sorts of mistakes, misjudgments, and violations of standards without triggering a complaint, while

therapists who fail to communicate these qualities must endure complaints even when they have otherwise seemed to adhere to the highest standards. This, of course, does not imply that it is somehow okay to bumble our way into careless mistakes, misjudgments, and violations or that we can use what we communicate to the client to justify, discount, trivialize, or rationalize what we've done wrong and the consequences of our behavior (see [Chapter 14](#)). Formal complaints sometimes seem to represent a client's last desperate attempt to catch the attention of an unresponsive therapist.

## **APOLOGIZE AND ACCEPT RESPONSIBILITY?**

If the complaint is valid, we must choose whether to acknowledge what we did, accept responsibility, and apologize. It seems to be part of the human condition that it is hard for many of us to admit mistakes, especially when those mistakes have hurt someone, and to say we're sorry. It can be much harder when it will go on the record, may be influential in sustaining the validity of the complaint, and is given to someone who is angry—perhaps enraged—at us. Some friends and colleagues may loyally take our side and advise us to despise the person who filed the complaint and to fight the complaint no matter what.

When facing a valid complaint, therapists may carefully consider, in consultation with their attorney, apologizing, accepting responsibility, and—if possible and appropriate—trying to make things right. Discussion with an attorney is an important part of this consideration. Attorneys may advise that a therapist should not speak to a complainant once a formal complaint has been filed. The attorney can explain the legal consequences (e.g., possible effects on the resolution of the complaint) and possible formats (e.g., in some situations it may be prohibited for the therapist to contact the complainant directly).

There can be strong reasons for favoring and opposing a direct apology at this stage, depending on the circumstances, and it is impossible to foresee all the consequences and implications of taking or not taking this path. Each therapist must choose what is right for their own values and situation.

## WHAT ARE YOU WILLING TO HAVE DONE?

If you contest the charges, consider—*before* the adversarial process heats up—what you are willing to allow in defending your case. As an extreme hypothetical, imagine that an extremely fragile single mother sues you for malpractice. You believe her to be a basically good and competent person who has mistakenly but in good faith filed a suit against you. Whatever your view of her, the claim she has filed threatens your reputation, career, and income. If the verdict goes against you, referral sources may dry up, the licensing board may launch an investigation, and your work as an expert witness on the standard of care may disappear.

With all that at stake, would you be willing for your attorney to depose her and cross-examine her at trial in a way that misleadingly raises questions about her honesty? Would you be willing for the attorney to use your chart notes to create through innuendo the false impression that she is not an adequate mother and that perhaps she even neglected or abused her child? Would you be willing to testify (falsely) that she suffers from borderline personality disorder and threatened to sue you and ruin your reputation if you did go along with her attempts at seducing you?

Or would you be tempted to “clarify” your chart notes, a euphemism for changing your notes after the fact but submitting them as if they were contemporaneous? The potential self-serving justifications for submitting fraudulent records—a practice that is never ethical—are endless. Those notes may have been done hurriedly, may not have mentioned everything that was done, and may be misleading because of the way they were written. Wouldn’t it be better to copy over those notes so that they include the material that you had neglected to put in the first time around on what are, really, if you come to think of it, your draft notes? Wouldn’t it actually be a service to the court to remove the unintentional ambiguities along with the parts that are relatively unimportant, that clutter up your account of the treatment? In other words, stripped of its rationalization, would you be willing to hide your actual notes and submit a bogus chart more favorable to your defense?

Feeling attacked and facing the loss of reputation, career, and income can stir our most basic instincts to fight, to do anything to survive. It may tempt us toward unethical extremes, such as lying while testifying or committing a fraud on the court by submitting bogus chart notes that we've secretly doctored. It may draw us toward pretending our hands are clean by letting our attorney use unethical or unfair tactics on our behalf. A question worth asking before the process builds up too much steam is: Am I willing to win at any cost? If not, where do I draw the line? What, if anything, am I unwilling to do—or to have done by others in my defense—to “win”?

## **RECOGNIZE HOW THE COMPLAINT IS AFFECTING YOU**

Formal complaints can devastate us. They can hit us with all of these feelings and more:

- Numbing shock that suddenly reputation and career may be at stake.
- A sense of betrayal that someone we tried to help has turned against us.
- Fear of uncertainty and the unknown horrors in store for us.
- Reflexive self-blame, assuming that we must have done something terrible or else we would not be in this fix.
- Embarrassment, imagining that our colleagues now think the worst about us.
- Self-doubt; if we did so poorly with this patient that we wound up in court, what if our other patients sue us?
- Depression. An overall, and all encompassing feeling of sadness about being in this situation.
- Suspicion of our other patients (are they going to sue us?) and colleagues (is there anyone we trust to talk this over with?).
- Anxiety about what lies ahead—being deposed and cross-examined, who will be in the courtroom during the trial (the media?), and on and on and on.

- Obsessive and intrusive thoughts, finding it hard to think about anything else.
- Insomnia, tossing and turning, thinking endlessly about what has happened and what may happen.
- Catastrophizing.
- Loss of appetite, eating or drinking too much, or abusing prescription or illegal drugs as a response to the stress.

We believe that for some therapists, being sued can bring on reactions akin to posttraumatic stress disorder. If we can be honest about our reactions, we are in a better position to respond to those reactions constructively and in healthy ways.

## **GET THE HELP AND SUPPORT YOU NEED**

What help, if any, do you need in dealing with these reactions? Some clinicians return to therapy or start therapy for the first time. Some reach out to friends, colleagues, and family. An attorney's guidance can be invaluable in keeping what you say to others from becoming part of the case against you. Ethics experts in your state may be able to provide you and your attorney with additional consultation.

## **WHAT CAN THE ORDEAL TEACH?**

For understatement it is hard to beat: No one ever wishes a formal complaint or lawsuit. But this unwelcome process brings opportunity. For instance, we may find flaws and weaknesses in our policies, procedures, and approach to clinical work. We may learn to spot red flags in our practice and to do something about them. We may learn about our colleagues—who can we count on for support and who abandons and avoids us. We may learn how our own work and the complaints against us are evaluated during adversarial procedures. And in our reactions and decisions, we may learn about ourselves.



# Chapter 20

## ASSESSMENT, TESTING, AND DIAGNOSIS

Psychological assessment, testing, and diagnosis can change lives. These evaluations can help decide whether someone gets academic and work place accommodations, a job, custody, security clearance, declaration of disability, release from involuntary hospitalization, asylum, or deportation. Psychological evaluations can also shape a jury verdict or court sentence. Conducting an evaluation for all these different purposes requires different sets of competencies as well as tests and other methods validated to answer specific questions for specific populations. The process of planning, performing, and reporting assessments presents us with a range of ethical challenges.

The settings where we work can make these challenges more complex. For instance, in organizational settings, we can face limits on instruments available as well as the time and resources we devote to each assessment. In solo practice, we can face challenges in conducting evaluations that are ethical, accurate, useful, and consistent with current research and theory. We often lack the ready-made professional support, educational resources, and peer review that many clinics and hospitals provide through in-service training programs, grand rounds, case conferences, and program evaluation. As a result, we may need to work harder to update, improve, and monitor our practice.

Providing valid psychological assessment of diverse racial, ethnic, cultural populations, also requires clinicians to be trained and competent in the use of tests and methods for specific populations (Cory, 2020; Fujii, 2018; Shapiro et al., 2019; Tan et al., 2020; Vasquez, 2015; see also [Chapter 7](#)).

In this chapter, we provide strategies to broaden, deepen, and strengthen ethical awareness that we hope can be helpful in avoiding

pitfalls while making sure that diagnosis, testing, and assessment are as valid and useful as possible.

## **AWARENESS OF STANDARDS AND GUIDELINES**

The American Psychological Association (APA) and the Canadian Psychological Association (CPA) publish standards and guidelines for testing, assessment, and diagnosis. Reviewing them can help us make sure that our work meets the highest standards. For example, APA's (2017a) Ethical Principles and Code of Conduct includes sections relevant to assessment, including "Evaluation, Diagnosis, and Interventions in Professional Context," "Competence and Appropriate Use of Assessments and Interventions," "Test Construction," "Use of Assessment in General and with Special Populations," "Interpreting Assessment Results," "Unqualified Persons," "Obsolete Tests and Outdated Test Results," "Test Scoring and Interpretation Services," "Explaining Assessment Results," "Maintaining Test Security," "Forensic Assessments," and "Describing the Nature and Results of Psychological Services."

Similarly, the fourth edition of the Canadian Code of Ethics for Psychologists (2017a) includes relevant statements such as that psychologists "Establish procedures for reasonably ready access to confidential information about an individual or group in a psychological record to that individual or group when requested, unless non-access is required or justified by law (e.g., potential serious harm to a third party; potential serious harm to the physical, emotional, or mental health of the individual or group)" (Section III.15i) and that psychologists "protect the skills, knowledge, and interpretations of psychology from being misused, used incompetently, or made useless (e.g., loss of security of assessment techniques by others)" (Section IV.11).

APA and CPA publish other documents helpful in this area, including:

- APA's Guidelines for Test User Qualifications: An Executive Summary (Turner et al., 2001) (currently under review/revision)
- *Recommendations by the Canadian Psychological Association for Improving the North American Safeguards that Help Protect*

*the Public Against Test Misuse* (Simner, 1994)

- Professional practice guidelines for occupationally mandated psychological evaluations (APA, 2018a)
- Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change (APA, 2012d)
- Guidelines for Assessment of and Intervention with Persons with Disabilities (APA, 2012b)
- Guidelines for Psychological Evaluations in Child Protection Matters (APA, 2013a)
- Specialty Guidelines for Forensic Psychology (APA, 2013b)
- *Practice guidelines for providers of psychological services* (CPA, 2017c)
- *APA Guidelines for Psychological Practice with Boys and Men* (APA, 2018b)
- *APA Guidelines for Psychological Practice with Girls and Women* (APA, Girls and Women Guidelines Group, 2018c)
- Guidelines for Ethical Psychological Practice with Women (CPA, 2007)
- Guidelines for psychological practice with lesbian, gay, and bisexual clients (American Psychological Association, 2012c)
- Guidelines for psychological practice with older adults (APA, 2014)
- Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015)
- Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality (APA, 2017b)
- APA Guidelines on Race and Ethnicity in Psychology (APA, 2019a)
- *Guidelines for non-discriminatory practice* (CPA, 2017b)
- Guidelines for Psychological Practice for People with Low-Income and Economic Marginalization (APA, 2019c)

- Guidelines for the Practice of Telepsychology (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013)

## **STAYING WITHIN AREAS OF COMPETENCE**

Psychology degrees, internships, and licenses do not by themselves qualify a professional to complete psychological evaluations. Learning how to administer, score, and interpret psychological assessments require training, supervision, and experience. In addition, learning how to utilize each individual measure for psychological assessment requires its own specific training. Almost four decades ago, Hall and Hare-Mustin (1983) reported an APA ethics case showing how long psychologists have recognized that testing requires specific training:

one psychologist charged another with incompetence, especially in testing... CSPEC (Committee on Scientific and Professional Ethics and Conduct [the former name of the APA Ethics Committee]) reviewed the report of the state committee, which had carried out the investigation, and found that the person had no training or education in principles of psychological testing but was routinely engaged in evaluations of children in child custody battles. The committee found violation of Principle 2a, competence in testing, and stipulated that the member should work under the supervision of a clinical psychologist for one year (p. 718).

Overall, the administration of psychological testing requires specific competence based on formal education, training, and supervised experience in the specific instruments and with the populations with whom they will be utilized. This also applies to diagnosis, evaluation, and assessment more generally even if testing is not involved.

## **ENSURING THAT OUR TESTS AND ASSESSMENT METHODS STAY WITHIN THEIR AREAS OF COMPETENCE**

Competence is specific to the task and method. We may be competent to assess a child's intellectual strengths and weaknesses but not an adult's neuropsychological functioning. Our competence in one area does not automatically apply to another area. The tests and other assessment methods we use face the same limitation. A particular test, for example, might help us figure out whether clients are malingering but not whether they will respond better to group than individual therapy.

When we consider a particular psychological test, we must ask whether it is both valid and reliable for the use at hand and has been normed and validated for the relevant groups (e.g., age, language, culture) to which our client belongs. For example, the APA Ethics Code (2017a) urges psychologists to "use assessment instruments whose validity and reliability have been established for use with members of the population test. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation" (p. 13).

Perlin and McClain (2009) provide an example of important issues of equivalence to consider when taking culture into account:

Technical equivalence refers to the method of data collection. For example, in some cultures unfamiliar with formal testing, results may not lead to valid outcomes due to reluctance to disclose or confusion regarding testing... Metric equivalence refers to analysis of the same concepts across cultures and the notion that the construct can be measured through the same scale after proper translation. Statistical behavior of the items in each culture must be the same. Validity of the measurement itself is the most critical issue in the cross-cultural application of testing. In other words, do the results really represent the issues being measured? Validity for the threshold or cutoff point refers to the point at which results should be considered impaired or psychopathological. Decisions about the criteria for threshold should be determined based upon sociocultural considerations and will likely affect various cultural groups differently (p. 265).

# **UNDERSTANDING MEASUREMENT, VALIDATION, AND RESEARCH**

Being able to document substantial course work, supervised training, and extensive experience in a given area like neuropsychological assessment of geriatric populations, intelligence testing of young children, or personality testing of adults helps a professional to establish competence in that area of testing in an ethics committee hearing, licensing hearing, or malpractice suit. But a basic understanding of measurement, validation, and research is another key component of competence.

Sanders and Keith-Spiegel (1980) described an APA ethics case in which a psychologist evaluated a person using a Minnesota Multiphasic Personality Inventory (MMPI), among other resources. The person who was evaluated felt that the test report, particularly the part based on the MMPI results, was not accurate. All materials, including the test report and raw data, were submitted to the APA Ethics Committee, which in turn submitted the materials for evaluation to two independent diplomates with expertise in testing.

The committee concluded that the psychologist did not demonstrate adequate understanding of measurement, validation, and inference in his report:

The only test used by the complainee that has any established validity in identifying personality disorders is the MMPI, and none of the conclusions allegedly based on the MMPI are accurate. We suspect that the complainee's conclusions are based upon knowledge of a previous psychotic episode and information from the psychiatric consultant, whose conclusions seem to have been accepted uncritically. The complainee's report is a thoroughly unprofessional performance, in our opinion. Most graduate students would do much better (Sanders & Keith-Spiegel, 1980, p. 1098).

# **ENSURING THAT PATIENTS UNDERSTAND AND CONSENT TO TESTING**

Making sure that a patient understands the nature and purposes of a given instrument helps to fulfill the client's right to give or withhold informed consent to assessment or treatment (see [Chapter 16](#)).

Making sure that the patient understands how testing differs from just presenting the information. Some patients may be anxious, distracted, preoccupied, or so eager to please that they nod their heads and are eager to sign consent when in fact they have understood none of what you've said. Some patients are unfamiliar with technical terms and concepts that we take for granted. Often this lack of communication combines with our own eagerness to get on with the testing and the client's fear of appearing ignorant.

The clinician is responsible for both explaining the assessment process in a way that clients can understand and for forming a professional opinion about whether the patient understands and consents. For a patient to be adequately informed, the consent must be given or withheld in the light of awareness of who will or may receive the results, which in turn may be affected by the Health Insurance Portability and Accountability Act (HIPAA) and other legislation (see [Chapter 21](#)). Although these issues concern the variety of people who may eventually receive copies of the report, and in some cases the associated raw data, the issues must be discussed with the patient before starting the assessment, so that the client's decision to give or withhold consent is adequately informed. The next section discusses clarifying these issues.

## **CLARIFYING ACCESS TO THE TEST REPORT AND RAW DATA**

We work within a complex framework of legal and ethical standards governing the discretionary and mandatory release of test information. The US Privacy Act of 1974, *Detroit Edison v. National Labor Relations Board* (1979), the 1996 HIPAA, and the Canadian 2000 Personal Information Protection and Electronic Documents Act (PIPEDA, last amended on June 21, 2019) are examples of legislation and case law that affect access to assessment documents.

The APA Ethics Code (APA, 2017a) Standard 9.04, Release of Test Data, (a) and (b) provides a definition of *test data* and guidance

about the release of test data:

- a. The term “test data” refers to raw and scaled scores, patient responses to test questions or stimuli, and psychologists’ notes and recordings concerning patient statements and behavior during an examination. Those portions of test materials that include patient responses are included in the definition of test data. Pursuant to a patient release, psychologists provide test data to the patient or other persons identified in the release. Psychologists may refrain from releasing test data to protect a patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law (see also Standard 9.11, Maintaining Test Security).
- b. In the absence of a patient release, psychologists provide test data only as required by law or court order.

The next fictional vignette shows the complex judgments therapists must make about withholding or disclosing assessment information:



A 17 year-old teenager comes to your office and asks for a comprehensive psychological evaluation. The teenager has been experiencing some headaches, anxiety, and depression. A high school dropout, the teen has been married for a year and has a 1 year-old baby but has left the spouse and child and returned to live with parents. The teen works full time as an auto mechanic and has insurance that covers the testing procedures. You complete the testing. During the following year, you receive requests for information about the testing from a number of people including:

- The teen's physician, an internist.
- The teen's parents, who are concerned about depression.
- The teen's employer, in connection with a worker's compensation claim filed by the teenager.
- The attorney for the insurance company that is contesting the worker's compensation claim.
- The attorney for the teen's spouse, who is suing for divorce and for legal custody of the baby.
- The attorney for the teen, who is considering suing you for malpractice because the results of the tests were unsatisfactory.
- The boy himself, who is not sure he can trust even his own attorney to provide him with all the notes and information in the chart—He wanted to see first-hand what's in there.<sup>1</sup>

Each request asks for the full formal report, the original test data, and copies of each test (e.g., instructions and all items for the MMPI-2).

To which of these people are you ethically or legally obligated to supply all information requested, partial information, a summary of the report, or no information at all? Which requests require the teen's written informed consent for release of information?

There is no set of answers to these complex questions that would fit all or even most readers. Each state, province, and other jurisdiction has its own evolving legislation and case law that address, sometimes

in an incomplete or confusing manner, clinician responsibilities. Such questions can, however, provide a basis for discussion in ethics courses, clinical supervision and consultation, staff meetings, or workshops. Answers can be looked up for a specific jurisdiction.

Practitioners can work through their local professional associations to develop clear guidelines to legal requirements. If the legal requirements in this or any other area of practice seem unethical, unreasonable, unclear, or potentially damaging to clients, we can propose and support remedial legislation.

## **FOLLOWING STANDARD PROCEDURES FOR ADMINISTERING TESTS**

When we are reciting the instructions to the Wechsler Intelligence Scale for Children—fourth edition (WISC-IV) or the Halstead Category Test for the 500th time, we may experience the urge to break the monotony, liven things up, and let our originality show through. And when we are in a hurry, we may want to shorten the instructions. After all, the client will catch on as we go along.

The assumption underlying standardized tests is that the test-taking situation and procedures are as similar as possible for everyone. If we change the procedures on which the norms are based, the standardized norms lose their direct applicability and the “standard” inferences drawn from those norms fall into question.

Reasonable accommodations for assessing people with disabilities may sometimes include changing the method of test administration. Lee et al. (2003) wrote:

The 1999 Standards for Educational and Psychological Testing adopted by AERA [American Educational Research Association], APA, and NCME [National Council on Measurement in Education] requires examiners to make reasonable accommodations for individuals with disabilities when administering psychological tests to such persons. Changes in test administration may be required, but the Standards also require the examiner to provide evidence associated with the validity of test score interpretation in the face of such changes in administration. Departures from standard procedures during test administration may change the meaning of test scores, because scores based on norms derived from standardized procedures may not be appropriate; error terms and rates may also be affected (p. 55).

APA's Committee on Professional Standards (1984) published a finding that allowing a client to take home a test such as the MMPI departs from the "standard procedure." The "Casebook for Providers of Psychological Services" (Committee on Professional Standards, 1984) describes a case in which a psychologist permitted his client to take the MMPI home to complete. When the complaint was filed with APA, the Committee on Professional Standards stated that whenever a psychologist

does not have direct, first-hand information as to the condition under which the test is taken, he or she is forced (in the above instance, unnecessarily) to assume that the test responses were not distorted by the general situation in which the test was taken (e.g., whether the client consulted others about test responses). Indeed the psychologist could have no assurance that this test was in fact completed by the client. In the instance where the test might be introduced as data in a court proceeding, it would be summarily dismissed as hearsay evidence (p. 664).

Unless the assessment is carefully monitored, there is no way to know the conditions under which the person filled out response sheets and completed other aspects of the testing. Psychologist Jack Graham, an expert in the MMPI, described an interesting test administration in an inpatient setting (Pope, Butcher et al., 2006). He noticed a large gathering of patients. Several times a minute,

some of the patients would raise their hands. Graham became intrigued and asked one of the patients to tell him what was going on. The patient explained that a psychologist had given an MMPI to one of the patients, asking him to complete it and then return it to the psychologist's office. The patient had asked for help from the other patients. The patient was reading each MMPI item aloud, and the patients raised their hands to vote on whether that item should be answered true or false.

Psychologist James N. Butcher, another expert in the MMPI, observed a patient sitting with his spouse outside a psychologist's office while filling out an MMPI. From time to time as the patient marked an answer, his wife, reading along, would tell him he was wrong and should change his answer, which the patient dutifully did (Pope, Butcher et al., 2006).

## **KNOWING THE LITERATURE ON RECORDINGS AND THIRD-PARTY OBSERVERS**

If we audiotape or videotape an assessment, or allow a third party to be present, we need to know how this can affect the assessment. For example, Constantinou et al. (2002) found that “in the presence of an audio-recorder the performance of the participants on memory tests declined. Performance on motor tests, on the other hand, was not affected by the presence of an audio-recorder” (p. 407). Gavett et al. (2005) found that “third party observers have been found to significantly impair neuropsychological test performance on measures of attention, verbal memory, verbal fluency, and cognitive symptom validity” (p. 49; see also Constantinou et al., 2005; Eastvold et al., 2012; Kehrer et al., 2000; Lynch, 2005; Yantz & McCaffrey, 2005). The degree to which third-party observers affect neuropsychological test performance may depend on such factors as autistic traits and the social awareness of the person being evaluated (Griffin & Gavett, 2018).

We also need to be aware of the policy statements and similar articles in this area. For example, the documents that address third-party presence in neuropsychological assessments include:

- Policy Statement of the American Board of Professional Neuropsychology regarding Third Party Observation and the recording of psychological test administration in neuropsychological evaluations (Lewandowski et al., 2016)
- American Academy of Clinical Neuropsychology's "Policy Statement on the Presence of Third-Party Observers in Neuropsychological Assessment" (2001)
- Axelrod and colleagues' "Presence of Third-Party Observers During Neuropsychological Testing: Official Statement of the National Academy of Neuropsychology" (2000)
- Duff and Fisher's "Ethical Dilemmas with Third Party Observers" (2005)
- Lynch and McCaffrey's "Neuropsychological Assessments in the Presence of Third Parties: Ethical Issues and Literature Review" (2004)

The Canadian Psychological Association (2009) issued the following policy statement:

It is not permissible for involved third parties to be physically or electronically present during the course of neuropsychological or similar psychological evaluations of a patient or plaintiff. Exceptions to this policy are only permissible when in the sole professional opinion of the assessing psychologist, based on their clinical judgment and expertise, that a third party would allow more useful assessment data to be obtained. Typical examples may include the inclusion of a parent or caregiver until a full rapport is gained. The presence of these observers should be cited as a limitation to the validity of the assessment (para. 10).

The APA's Committee on Psychological Tests and Assessment (2007) summarizes complex issues involving third parties:

Inclusion of a third party in the assessment and testing process may affect validity of an evaluation or threaten test security and copyright. However, a third party may facilitate validity and fairness of the evaluation or be required by law. Options to address the request for external observation include but are not limited to (1) conducting the evaluation in the presence of an observer, (2) minimizing the intrusion afforded by observation, (3) utilizing assessment measures that are less affected by observation, (4) recommending that the request for a third party be withdrawn, and (5) declining to perform the assessment under observation (p. 5).

## **AWARENESS OF BASIC ASSUMPTIONS**

Fundamental assumptions and theoretical frameworks often affect our assessments. Langer and Abelson's classic study (1974), "A Patient by Any Other Name," for example, shows one way in which behavior therapists and psychoanalytically oriented therapists can differ when viewing the same individual:

Clinicians representing two different schools of thought, behavioral and analytic, viewed a single videotaped interview between a man who had recently applied for a new job and one of the authors. Half of each group was told that the interviewee was a "job applicant" while the remaining half was told that he was a "patient." At the end of the videotape, all clinicians were asked to complete a questionnaire evaluating the interviewee.

The interviewee was described as fairly well adjusted by the behavioral therapists regardless of the label supplied. This was not the case, however, for the more traditional analytic therapists. When the interviewee was labeled "patient," he was described as significantly more disturbed than he was when he was labeled "job applicant" (p. 4).

The point here is not whether either of these two orientations is more valid, reliable, respectable, empirically based, or useful but rather to underscore the obvious—that is, different theoretical orientations can lead to different assessments. Clinicians conducting assessments and assigning diagnoses need to be continually aware of their own

theoretical orientation and how that orientation will affect the evaluation. Langer and Abelson (1974) wrote:

Despite the questionable light in which the analytic therapist group was cast in the present study, one strongly suspects that conditions might be arranged wherein the behavior therapists would fall into some kind of error, as much as the traditionalists. No single type of orientation toward clinical training is likely to avoid all types of biases or blind spots (p. 9).

Woodward et al. (2009) conducted a similar study and wrote:

The finding that psychodynamic therapists were more likely to diagnose BPD [borderline personality disorder] than PTSD [posttraumatic stress disorder] is consistent with previous research which has found that psychodynamic clinicians tend to apply the BPD diagnosis when BPD criteria are not met more frequently than clinicians of other orientations .... It is also of note that in the current study, CBT [cognitive behavioral therapy] clinicians were more likely to diagnose PTSD than BPD. That theoretical orientation significantly affects a clinician's diagnosis raises concerns because it suggests that clinicians may be applying their own theories to the atheoretical diagnostic criteria of *DSM-IV* [*Diagnostic and Statistical Manual of Mental Disorders*, 4th ed.]. How clinicians conceptualize their clients' distress will impact those clients' treatment plans and possibly the effectiveness of the intervention. We encourage clinicians to reflect upon their own theoretical biases when assessing new clients and to form comprehensive treatment plans to address those difficulties most relevant for each patient (p. 287).

## **AWARENESS OF PERSONAL FACTORS LEADING TO MISUSING DIAGNOSIS**

In addition to a lack of awareness of our basic assumptions and our assumptions in specific areas, insufficient attention to our own personal reactions and dynamics makes us vulnerable to faulty evaluations. Reiser and Levenson's excellent article, "Abuses of the Borderline Diagnosis" (1984), focuses on six ways in which the

diagnosis of borderline personality disorder is commonly abused “to express countertransference hate, mask imprecise thinking, excuse treatment failures, justify the therapist’s acting out, defend against sexual clinical material, and avoid pharmacologic and medical treatment interventions” (p. 1528). Openness to such issues within ourselves and frequent consultations with colleagues can help prevent abuses of this kind and help our assessments meet the highest ethical standards.

## **AWARENESS OF FINANCIAL FACTORS LEADING TO MISUSING DIAGNOSIS**

Therapists who depend on third-party coverage learn quickly which diagnostic categories are “covered” and which are not. Insurance companies, health maintenance organizations (HMOs), and managed care companies may authorize services for only a very restricted range of diagnoses. For example, the personality or character disorders are rarely covered. Unfortunately, the temptation to substitute a fraudulent but covered diagnosis for an honest but unreimbursable one can influence even senior and well-respected practitioners, as shown in a national study (Pope & Bajt, 1988). In his strongly worded article on insurance billing, Kovacs (1987) warned that those

who are naive about insurance billing or who play a little fast and loose with carriers are beginning to play Russian Roulette. The carriers are now prepared to spend the necessary funds for investigators and for lawyers which will be required to sue in civil court and/or to bring criminal charges against colleagues who do not understand their ethical and legal responsibility in completing claim forms on behalf of their patients (p. 24).

“Advice on Ethics of Billing Clients” (1987), an article in the *APA Monitor*, lists among “billing practices that should be avoided”: “Changing the diagnosis to fit reimbursement criteria” (p. 42).

The APA’s Ethical Principles of Psychologists and Code of Conduct (2017a), Standard 6.06, Accuracy in Reports to Payors and Funding Sources, states:



In their reports to payors for services or sources of research funding, psychologists take reasonable steps to ensure the accurate reporting of the nature of the service provided or research conducted, the fees, charges, or payments, and where applicable, the identity of the provider, the findings, and the diagnosis (See also Standards 4.01, Maintaining Confidentiality; 4.04, minimizing Intrusions on Privacy; and 4.05, Disclosures).

Unfortunately, many third-party payers limit reimbursement for assessment to one hour or a similar short segment. Often a full evaluation to determine accurate diagnoses requires several hours of testing and report preparation. Either the clinician must provide rationale for further reimbursement or provide services pro bono. (Note: Finn, 2007 describes an assessment process that has therapeutic impact and also describes how to bill third-party payers for therapeutic assessment sessions.)

The problem of financial factors leading to false diagnosis appears to be significant. Gross (2004) wrote that

the abuse of insurance is one of the most common ethical and legal violations committed by practicing therapists, resulting in imposed sanctions by licensing agencies and criminal convictions .... Unfortunately for the profession, abuse of insurance has become so commonplace that many practitioners have deceived themselves into believing it is normal or acceptable behavior (p. 36).

## **ACKNOWLEDGING LOW BASE RATES**

If an assessment involves a factor—for example, a condition, ability, aptitude, or quality—rarely found in the population, overlooking the low base rate causes problems. Even when psychological tests are accurate, low base rates can cause big mistakes (Pope, 2003).

Imagine you have been commissioned to develop an assessment procedure that will identify crooked judges so that candidates for judicial appointment can be screened. It is a difficult challenge, in part because only 1 out of 500 judges is (hypothetically speaking) dishonest.

You pull together all the actuarial data you can find and develop a screening test for crookedness based on personality characteristics, personal history, and test results. Your method is 90% accurate.

When your method is used to screen the next 5,000 judicial candidates, there might be 10 candidates who are crooked (because about 1 out of 500 is crooked). A 90% accurate screening method will identify 9 of these 10 crooked candidates as crooked and 1 as honest.

So far, so good.

The problem is the 4,990 honest candidates. Because the screening is wrong 10% of the time and the only way for the screening to be wrong about honest candidates is to identify them as crooked, it will falsely classify 10% of the honest candidates as crooked. The test will incorrectly classify 499 of these 4,990 honest candidates as crooked.

So out of the 5,000 candidates who were screened, the 90% accurate test classified 508 of them as crooked; nine who actually were crooked and 499 who were honest. Every 508 times the screening method indicates crookedness, it tends to be right only nine times. And it has falsely branded 499 honest people as crooked.

## **ACKNOWLEDGING DUAL HIGH BASE RATES**

The next example shows why it is crucial to recognize dual high base rates:

As part of a disaster response team, you are flown in to work at a community mental health center in a city that has experienced a severe earthquake. Taking a quick look at the records the center has compiled, you note that of the 200 people who have come for services since the earthquake, there are 162 who are of a particular religious faith and are diagnosed with posttraumatic stress disorder (PTSD) related to the earthquake and 18 of that faith who came for services unrelated to the earthquake. Of those who are not of that faith, 18 have been diagnosed with PTSD related to the earthquake, and 2 have come for services unrelated to the earthquake.

It looks like there is a strong link between that particular religious faith and developing PTSD related to the earthquake: 81% of the people who came for services were of that religious faith and had

developed PTSD. Perhaps this faith makes people vulnerable to PTSD. Or perhaps it is a more subtle association; this faith might make it easier for people with PTSD to seek mental health services.

But the inference of an association is a fallacy; religious faith and the development of PTSD in this community are independent factors. Ninety percent of all people who seek services at this center happen to be of that specific religious faith (90% of those who had developed PTSD and 90% who had come for other reasons) and 90% of all people who seek services after the earthquake (90% of those with that particular religious faith and 90% of those who are not of that faith) have developed PTSD. The two factors appear to be linked because both have high base rates, but they are statistically unrelated (Pope, 2003).

## **AVOIDING CONFUSION BETWEEN RETROSPECTIVE AND PREDICTIVE ACCURACY**

The predictive accuracy of an assessment instrument focuses first on the test results and asks: What are the chances, expressed as a conditional probability, that a person with these results has a particular condition, ability, aptitude, or quality? The retrospective accuracy of an assessment instrument focuses first on the particular condition, ability, aptitude, or quality and asks: What are the chances, expressed as a conditional probability, that a person who has this particular condition or ability will show these test results? Many problems spring from this common mistake of confusing the directionality of the inference.

This mistake of confusing retrospective with predictive accuracy often resembles the “affirming the consequent” logical fallacy (see [Chapter 11](#)):

People with condition X are overwhelmingly likely to have these specific test results.

Person Y has these specific test results.

Therefore, Person Y is overwhelmingly likely to have condition X.

## AWARENESS OF FORENSIC ISSUES

As our society becomes more litigious, we find ourselves appearing in court more frequently as fact witnesses (if we are testifying about our therapy client) or as expert witnesses and preparing documents that will become part of legal proceedings. Forensic settings are a baffling brave new world for many therapists, and we need to become aware of ground rules. For example, financial factors can, under certain circumstances, create a bias—or at least the appearance of bias—in conducting out and reporting assessments. For this reason, forensic texts have long mandated that no psychologist accept a contingency fee. Blau (1984) wrote: “The psychologist should never accept a fee contingent upon the outcome of a case” (p. 336). Shapiro (1990) stated: “The expert witness should never, under any circumstances, accept a referral on a contingent fee basis” (p. 230). Only about 15% of the respondents in a national survey reported engaging in this practice (Pope et al., 1987), and about the same percentage (14%) believe it to be good practice or good under most circumstances (Pope et al., 1988). Kesselheim and Studdert (2007) note that “many codes ... reject witness fees that are contingent on the litigation outcome” (p. 2907). The Committee on Medical Liability and Risk Management of the American Academy of Pediatrics (2009) emphasizes that “the medical profession has deemed it unethical for expert witnesses to base their fees for testifying contingent on the outcome of the case” (p. 433). The *APA Specialty Guidelines for Forensic Psychology* state: “Because of the threat to impartiality presented by the acceptance of contingent fees and associated legal prohibitions, forensic practitioners strive to avoid providing professional services on the basis of contingent fees” (APA, 2013, p. 12). In many instances the contingency fee is not only an ethical issue and one of objectivity, but also a legal concern. Wertlieb (2017) notes that in most jurisdictions the common law rule holds that paying a contingency fee to an expert witness is improper.

## HIGH STAKES TESTING

Intelligence and other forms of testing are “high stakes” and may be used for admission to educational programs, special education, employment selection and even death penalty cases. Translation and

adaptation of various tests can be challenging in use with various subcultures and languages. Overlooking factors like language, level of acculturation, education, and socioeconomic status can lead to invalid results, with disastrous consequences, when assessing intelligence, competence, disability, neuropsychological status, and so on (Benuto & Leany, 2015; Brown et al., 2015; Cervantes et al., 2016; Harry & Klingner, 2014; Ortiz & Melo, 2015; Puente et al., 2015; Vasquez, 2015).

The case of *Ewert v. Canada* (2018) illustrates the failure of a government to take into account cultural issues in psychological testing, with catastrophic results. An indigenous inmate, Mr. Jeffrey G. Ewert, persisted for 18 years until his case was finally heard by the Supreme Court of Canada. He argued that the 5 actuarial tests used to assess his potential recidivism were culturally biased, were not valid when used with indigenous prisoners, and had no established predictive value for his own behavior. The Court held:

The CSC [Correctional Services of Canada] had long been aware of concerns regarding the possibility of these tools exhibiting cultural bias yet took no action to confirm their validity and continued to use them in respect of Indigenous offenders, despite the fact that research would have been feasible. In doing so, the CSC did not meet the legislated standard set out in s. 24(1). This conclusion is supported by the interpretation and application of the guiding principle set out in s. 4 (g) of the CCRA. This principle requires that correctional policies, programs and practices must respect gender, ethnic, cultural and linguistic differences and must be responsive to the special needs of equity-seeking groups, and in particular Indigenous persons. Section 4 (g) represents an acknowledgement of the systemic discrimination faced by Indigenous persons in the Canadian correctional system. It is evident from the grammatical and ordinary sense of the words of s. 4 (g) and the legislative history of the CCRA that s. 4 (g) should be understood as a direction from Parliament to the CSC to advance substantive equality in correctional outcomes for Indigenous offenders. It is critical that the CSC give this direction meaningful effect. In the context of the present case, this means, at a minimum, addressing the long-standing, and credible, concern that continuing to use the impugned tools in evaluating Indigenous inmates perpetuates discrimination and disparity in correctional outcomes between Indigenous and non-Indigenous offenders. The CSC must ensure that its policies and programs are appropriate for Indigenous offenders and responsive to their needs and circumstances. For the correctional system to operate fairly and effectively, the assumption that all offenders can be treated fairly by being treated the same way must be abandoned. The CSC's inaction with respect to the concerns raised about the impugned tools fell short of what s. 24(1) required it to do (para. 9).

Perhaps some of the highest stakes testing is conducted in death penalty cases. Shapiro et al. (2019; see also Walker et al., 2020) provide examples and analysis of cases in which a defendant's obtained I.Q. score has been raised on the basis of what prosecution experts term "cultural adjustment" so that they would not be

disqualified from the death penalty. Shapiro and colleagues point out that the “cultural adjustment” lacks empirical support and validity.

## **ATTENTION TO POTENTIAL MEDICAL CAUSES**

Whenever the patient’s symptoms hit all of the diagnostic criteria for a psychological disorder, it is tempting to ignore possible medical causes for distress or disability. A comprehensive evaluation, however, needs to rule out (or identify) possible medical causes.

Rick Imbert, when he was president of the American Professional Agency, a company that provides professional liability coverage, stressed that “if there is any indication of a physical problem, then have a full medical screening; for example, symptoms which appear to be part of a schizophrenic process can actually be caused by a brain tumor” (personal communication, April 18, 1988). The case of Mr. Alvarez in [Chapter 2](#) reminds of what can happen when we reflexively dismiss possible physical causes for symptoms that appear to have psychological causes.

## **CRITICALLY EXAMINING PRIOR RECORDS AND HISTORY**

Prior records of assessment and treatment can provide invaluable information and context to a comprehensive psychological evaluation. The courts have held that neglecting to make any effort to recognize, obtain, and use this resource violates, in some instances, the standard of care. In the federal case of *Jablonski v. United States* (1983), for example, the US Ninth Circuit Court of Appeals upheld a “district court judge’s findings of malpractice ... for failure to obtain the past medical records.”

Critical examination is crucial. Some records may contain information that is wrong, biased, misleading, or out of date. Test scores may be based on tests that have been revised or shown to produce questionable results for the purpose at hand. Prior intelligence testing may have used inappropriate norms in light of the Flynn Effect (the general population’s performance on

intelligence tests improves over time). Pietschnig and Voracek's (2015) meta-analysis of the Flynn Effect from 1909 to 2010 found

a Flynn effect of about 3 IQ points per decade. However, this estimate reflects global linear gains by assuming uniform gains over a period of more than 100 years. The data suggest that this assumption may well not be justified, as the strength of gains could be shown to vary according to country, intelligence domains, and the investigated time span (p. 296).

Regardless of whether prior records exist or are obtainable, obtaining an adequate history can be crucial to an adequate assessment. Psychologist Laura Brown (1994), for instance, discussed the pioneering work of independent practitioner Lynne Rosewater and George Washington University professor Mary Anne Dutton in demonstrating how overlooked history could lead to misdiagnosis when relying on standardized tests:

Their work has involved collecting data on large numbers of battered women and identifying common patterns of response on the testing. In effect, they have noted that the standard mainstream texts and computerized scoring systems for the MMPI do not take into account the possibility that the person taking the test is a woman who currently is, or recently has been, beaten by her spouse or partner ....

As Rosewater first pointed out, without the context, specifically the identification of the presence of violence, battered women look like schizophrenics or borderline personalities on the MMPI. With the context of violence explicitly framing the interpretation of the test findings, however, it is possible to note that the sort of distress indicated on the testing is a reasonable response to events in the test-taker's life. That is to say, when a woman's partner is beating her, it makes sense that she is depressed, confused, scattered, and feeling overwhelmed. It is not necessarily the case that this state of response to life-threatening violence is either usual for the woman in question or a sign of psychopathology (p. 187).



## **CLEARLY STATE ALL RESERVATIONS ABOUT RELIABILITY AND VALIDITY**

If any circumstances might have affected the results of psychological testing, such as dim lighting, frequent interruptions, a noisy environment, or medication, or if there is doubt that the person being tested shares all relevant characteristics with the reference groups on which the norms are based, these factors and their possible implications need to be appear clearly in the formal report.

This means we must remain alert to the diverse array of factors that may affect the validity and reliability of the testing. For example, if we test someone whose first language is not English, we must decide whether the testing in English is appropriate. Often, referral of the client to a mental health professional who is competent in the client's language is the best course. If translation is necessary, we avoid if at all possible, relying on a translator who has the kind of dual role with the client (e.g., a family member) that may jeopardize the validity of the client's responses. Clients may feel ashamed, embarrassed, or afraid to say certain things in front of a family member. They may be reluctant to say something that might irritate, anger, sadden, embarrass, or shock a mother, father, son, daughter, or other family member. They may fear that their relative will share what they are saying with other family members or friends. They may be concerned that the relative will want to talk with them about topics that they are mentioning only as part of the assessment and do not wish to discuss with anyone.

## **AVOIDING THE CULTURAL EQUIVALENCY FALLACY IN ASSESSMENT**

Evaluating and testing Black, Indigenous, and People of Color (BIPOC) adds additional layers of complexity to an already comprehensive process. For instance, the client's linguistic, cultural, and racialized experiences also need to be carefully considered throughout the assessment process and when interpreting clinical data including standardized measures. Several clinical, intellectual and other assessment instruments that have been translated,

normed, and validated with various ethnic minoritized populations (Vasquez, 2015). A competent examiner will review resources that provide reviews of measures and methods to assess their cultural equivalence, validity and reliability, and psychometric support (for example, see Geisinger, 2015). Lonner (1985) described four cultural equivalences for the therapist to consider when developing measures, interpreting psychological data, and developing interventions including: functional equivalence, conceptual equivalence, linguistic equivalence, and psychometric equivalence. According to Helms (2015), “failure to consider any of the aforementioned types of equivalence places one at risk of measuring and interpreting meaningless artifacts as if they were meaningful, or in other words, committing a ‘cultural equivalence fallacy’” (p. 190; see also Helms, 1992). [Table 20.1](#) provides recommendations to help us avoid committing a cultural equivalence fallacy during the evaluation process. Specifically, the table focuses on functional and psychometric equivalence and compares traditional assessment (i.e., not considering culture and race) with assessments that attend to clients’ racialized and cultural life experiences.

**[Table 20.1.](#)** Helms’ Assessment Equivalence Assumptions.

<b>Traditional Assessment and Intervention</b>	<b>Racially Conscious Assessment and Intervention</b>	<b>Culturally Responsive Assessment and Intervention</b>	
<b>Functional Equivalence</b>	<p>Symptoms are treated the same regardless of client’s cultural and racial dynamics.</p> <p><u>Assessment</u></p> <p>Standardized self-report measures, normed on</p>	<p>Symptoms may be interpreted or expressed according to racial stereotypes.</p> <p><u>Assessment</u></p> <p>Effects of racism (e.g., experiences of discrimination) should be</p>	<p>Nature of symptoms may be dependent on ethnic cultural norms, which may be misinterpreted .</p> <p><u>Assessment</u></p>

<b>Traditional Assessment and Intervention</b>	<b>Racially Conscious Assessment and Intervention</b>	<b>Culturally Responsive Assessment and Intervention</b>	Ethnic cultural norms may determine whether items describe functional behaviors in client's environments.
	<p>predominately White samples are interpreted in the same way regardless of race/ethnic cultural dynamics of the client.</p> <p><u>Example</u></p> <p>The same cutoff scores developed on predominately White samples are used to determine symptomatology in Latino/a samples.</p>	<p>not reveal depression symptoms to avoid being racially stereotyped.</p>	<p>Client may hide or describe functional behaviors in client's environments.</p> <p><u>Example</u></p> <p>Client may respond to items according to what is socially desirable in their cultural environment.</p>

<b>Traditional Assessment and Intervention</b>	<b>Racially Conscious Assessment and Intervention</b>	<b>Culturally Responsive Assessment and Intervention</b>	
<b>Psychometric Equivalence</b>	<p>Treated and measured concepts are similarly engaging or disengaging across groups.</p>	<p>Race-related life experiences may be camouflaged in responses to self-report measures.</p>	<p>Cultural group experiences may influence style of responding.</p>
	<p><u>Assessment</u></p>	<p><u>Assessment</u></p>	<p><u>Assessment</u></p>
	<p>Measures with evidence of good psychometric properties (e.g., reliability) for some samples pertain to all populations.</p>	<p>Even if measures show evidence of similar responding between groups (e.g., reliability, factor invariance), different within-group explanations may exist.</p>	<p>Response styles (e.g., acquiescence, extreme responses) may characterize responses to scales.</p>
	<p><u>Example</u></p> <p>Scale scores are used as if they provided objective evidence about outcomes regardless of race/ethnicity of responders.</p>	<p><u>Example</u></p> <p>Scores on standard measures should be adjusted based on scores on measures of racial experiences (e.g., racial microaggressions).</p>	<p><u>Example</u></p> <p>Asians and Blacks may use mid-points of scales or end points more frequently than Whites depending on the perceived nature of the construct.</p>

<b>Traditional Assessment and Intervention</b>	<b>Racially Conscious Assessment and Intervention</b>	<b>Culturally Responsive Assessment and Intervention</b>
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*Note.* From “An Examination of the Evidence in Culturally Adapted Evidence-based or Empirically Supported Interventions,” by J.E. Helms, 2015, *Transcultural Psychiatry*, 52(2), p. 174–197. Copyright 2015 by Sage Publications. Adapted with permission.

## PROVIDING ADEQUATE FEEDBACK

Feedback is a dynamic, interactive process in which the results and implications of testing or other forms of assessment are shared with the person who is being assessed, and providing feedback is, with certain exceptions, a basic responsibility (Pope, 1992). APA (2017a) Ethics Code Standard 9.10, Explaining Assessment Results, states:

Regardless of whether the scoring and interpretation are done by psychologists, by employees or assistants, or by automated or other outside services, psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative unless the nature of the relationship precludes provision of an explanation of results (such as in some organizational consulting, preemployment or security screenings, and forensic evaluations), and this fact has been clearly explained to the person being assessed in advance.

Three major factors can block this process

1. HMOs and other managed care organizations can inflict harsh, sometimes unrealistic, demands on clinicians' time. The rationing of time may allow too little opportunity to sit with a client to discuss an assessment and attend carefully to the client's questions and concerns. Similarly, federal, state, and private mental health insurance may disallow coverage for all but the most minimal feedback session. For example, there may be a standard fixed payment for administering a specific psychological test; the payment may barely (sometimes inadequately) cover the time necessary to administer the test and

prepare a brief write-up of the results. The clinician may have to donate pro bono the time required to provide adequate feedback.

2. Advertisements and marketing literature may promote individual tests, versions of tests, or test batteries by stressing how little time they take. One continually reads of quick, brief, short, and abbreviated tests. Such promotion may unintentionally nurture the notion that a complex assessment can be carried out in just a few minutes with no real demands on the clinician's time, skills, judgment, or even attention. This rush to judgment may encourage clinicians to match their quick, brief, short, and abbreviated testing with quick, brief, short, and abbreviated feedback.
3. On a personal level, therapists and counselors may be uncomfortable discussing assessment results with a client. Some may be reluctant to be the bearer of what they fear the client will receive as bad news. Others may be uncomfortable trying to translate for the client the technical jargon that clogs so many test interpretation texts, computer interpretation printouts, volumes on diagnosis, and so forth. Still others may be uneasy facing a client's expectations of clear results with test results that may necessarily leave many important questions unanswered.

These and other factors may encourage clinicians to forget that feedback is a dynamic, interactive process that is an aspect of the larger process of assessment and that the assessment often continues during what is called the feedback session or phase. Consequently, feedback may come to be viewed as simply a pro forma, static method of closure or an obligatory technicality in which the "results" are dumped in the client's lap (or referral source or someone else). This view of feedback seems so aversive and unproductive that some clinicians may decide—wrongly—to withhold feedback altogether. No rote, by-the-numbers approach to feedback can replace a thoughtful discussion with the client of what the results are, what they mean, and what they do not mean.

# SCENARIOS FOR DISCUSSION

You are attending your first rounds at the community mental health center where you began working last week. Your supervisor discusses a recent intake who will be assigned to you for therapy. The supervisor, who assessed the new client using the MMPI-2 and a clinical interview, says that the assessment shows that the client's claims about being raped are clearly false. The treatment plan, which you will be implementing, will be to help the new client realize that this confabulation is not real.

- How do you feel?
- What options do you have?
- What would you like to say to the supervisor?
- What do you think that you would say to the supervisor?

...

You work for an HMO. A new patient shows up at your office for an initial session. The person says: "I have felt so incredibly edgy all week. I don't know what's wrong with me. But I feel like I want to smash someone in the mouth, like I want to get my gun and blow someone's brains out. I don't even know who, but it's like something's building up and it just won't be stopped".

- How do you feel?
- When the person stopped talking, what would be the first things you would say?
- How do you go about creating an assessment plan in this situation? What phases of the assessment would you make sure to complete before the person left your office, and how would you go about completing them? What phases of the assessment would you schedule for later?
- Who else, if anyone, would you involve in the assessment?

...

You are responsible for all intakes on Mondays, Wednesdays, and Fridays. After discussing recent intakes with you, your supervisor tells you: “From now on, I want to obtain standardized testing data on all intakes. I want you to administer the [names a test] to all intakes. I think we need to base our decisions on test data.”

You believe that this test lacks adequate validity and reliability for clinical work and is therefore not useful. You diplomatically say that you are not sure about giving the test, but your supervisor says, “I can understand that. No method is endorsed by everyone. But I’m responsible for intakes, and I’ll take responsibility for this. All you need to do is administer, score, and interpret them”.

- How do you feel?
- What would you like to say to the supervisor?
- What do you think you’d end up saying to the supervisor?
- What are your options?
- What would you do?

• • •

A parent schedules an appointment with you. The parent shows up with a child and says, “The people at school say that my Jesse here cheats at school. Can you talk with Jesse and give some tests to find out if that’s true?”

- How do you feel?
- What are your options?
- What ethical concerns do you have? How would you address them?

• • •

A former client, whom you liked very much, calls and reports that she and her spouse are getting divorced. The client asks to return for an evaluation, as requested by her attorney, regarding a child custody dispute. She expresses her assumption that you will testify in court on her behalf.

- How do you feel?



- What are your options?
- What issues do you consider?
- How do you think you would respond?

• • •

An attorney calls to ask you to provide a basic evaluation for a patient who will be deported unless proof can be provided that the attorney's client is under severe duress as a refugee. The hearing is in one week, and the attorney says that no other resources for obtaining an evaluation are available and that there are waiting lists at the clinics providing such evaluations. The hearing judge has refused to grant an extension. The client does not speak English but has a family member who can interpret. You do not speak the client's language. You have attended multicultural diversity workshops and classes.

- How do you feel?
- What issues do you consider in deciding whether to schedule the assessment?
- What assessment approaches, including any standardized tests, would you consider in planning such an evaluation?
- Assume you agreed to conduct the assessment and when, you began, you found that the family member had minimal skills in speaking English.
- What would you do?

• • •

A close colleague of yours, to whom you owe many professional favors (she took care of your practice when you suddenly became sick and had to take a break), called to ask if you can help her out with a favor. The colleague needs you to complete a psychological evaluation for a "distant relative." Since you don't know the client and they are reportedly not close to your colleague you agree to schedule them for an appointment. While the referral question is not very clear, you are told that the client is a 12 year-old boy who has been experiencing significant problems with paying attention,

sleep, and appetite. During the clinical interview the child's mom, states "Thank you so much for seeing us. I am seeking a psychological evaluation to find out what is wrong with my son." She reports that for the past few years he has been "losing his mind." She reports that the child "feels like a girl and not a boy and keeps on insisting wearing girls' clothing." She says that she feels desperate and wants to "once and for all know" what is happening to her son and how to stop him from "going crazy".

- How do you feel?
- What would you do when you find out what mom wants you to do?
- How would you respond?
- Would you still complete the psychological evaluation?

## Notes

- <sup>1</sup> Thanks to Dr. Bruce Borkosky for suggesting the final request for records.

# Chapter 21

## CONFIDENTIALITY

Our unwavering commitment to client's well-being, our responsibility to being trustworthy, and our duty to protect their private information is at the heart of the work that we do as clinicians. In therapy, clients trust us to guard their confidences. They trust that the digital records of their diagnosis, treatment plan, home address, and billing information will not spill out onto the internet, finding their way to social media, curious eyes, and identity thieves. They trust that we will lock up paper charts. They trust us not to discuss their treatment with colleagues as we walk down hospital halls, eat in the clinic cafeteria, or chat on a cell phone at the train station.

Leaks of all kinds can cause many problems. A rushed response to a subpoena may allow a law firm to get documents they have no right to. A phone message asking a client to return a call may allow the perpetrator of domestic violence to discover that despite his warnings his partner has reached out to a therapist.

The consequences of seemingly confidential information being passed along without the client's awareness can hit clients without warning and cause serious consequences. According to a Canadian Broadcasting Corporation (CBC) News report

more than a dozen Canadians have told the Psychiatric Patient Advocate Office in Toronto within the past year that they were blocked from entering the United States (U.S.) after their records of mental illness were shared with the U.S. Department of Homeland Security .... According to diplomatic cables released earlier this year by WikiLeaks, any information entered into the national Canadian Police Information Centre (CPIC) database is accessible to American authorities. Local police officers take notes whenever they apprehend an individual or respond to a 911 call, and some of this information is then entered into the CPIC database, says Stylianos .... [RCMP Insp. Denis St. Pierre says the CPIC] “also can contain individuals’ history of mental illness, including suicide attempts”(Bridge, 2011, paras. 1, 14, 17; see also “Canadians’ mental-health info routinely shared with FBI, U.S. customs” 2014).

In another instance of sharing clinical information without the individual’s knowledge or consent so that the information could be weaponized and used against a vulnerable individual, the U.S. Immigration and Customs Enforcement (ICE) obtained the psychotherapy records of child immigrants and used them against the children in deportation hearings (Canady, 2020; see also Izquierdo, 2020; Nilsen, 2018).

Clinicians may communicate, with the client’s consent, confidential clinical information to insurance companies, employee-assistance companies, and other agencies as a condition of coverage. With increasing frequency, these arrays of confidential information are subsequently aggregated into large research databases in ways intended to make it impossible to identify individual clients. But can sophisticated strategies re-identify individuals and put the information into the hands of advertisers, loan officers, employment screeners, law enforcement, credit monitoring agencies, and others willing to pay for the data or extract it on their own?

Latanya Sweeney, Director of Harvard’s Data Privacy Lab, reported in a *Scientific American* interview that she had re-identified people with Huntington’s disease, although all identifying information had been removed in creating a large database. She described how a banker followed a cross-referencing strategy when looking at

publicly available de-identified data “to see if any of his clients had cancer. If they did, he called in their loans” (Walter, 2007, p. 92; see also Benitez & Malin, 2010; El Emam et al., 2011; Gymrek et al., 2013; Loukides et al., 2010; Rothstein, 2010).

Ohm (2010) wrote that

scientists have demonstrated they can often ‘reidentify’ or ‘deanonymize’ individuals hidden in anonymized data with astonishing ease. By understanding this research, we will realize we have made a mistake, labored beneath a fundamental misunderstanding, which has assured us much less privacy than we have assumed. This mistake pervades nearly every information privacy law, regulation, and debate ....”(p. 1701).

The U.S. *President’s Council of Advisors on Science and Technology* reported: “Long used in health-care research and other research areas involving human subjects, anonymization (also termed deidentification) applies when the data, standing alone and without an association to a specific person, do not violate privacy norms .... Unfortunately, it is increasingly easy to defeat” (2014, p. 38; see also Daries et al., 2014).

Rocher et al. (2019) developed an approach to finding the identities of people in heavily anonymized data sets. They found that 99.98% of people in the U.S. could be correctly identified in any anonymized data set that included 15 demographic attributes. The above-mentioned research is troubling as it illustrates the problem when participants are led to believe that their information is protected when it is not.

Confidentiality helps clients talk freely but tends to trip up us therapists from time to time and calls for us to strengthen our ethical awareness. We’re all human and none of us can catch and counter all potential threats to confidentiality. Fatigue, stress, and routine dull our awareness, lull us into ethical sleep, put us on automatic when we need to be fully woke to be aware of what we may be missing. Threats to confidentiality can disappear into the demands and distractions of our work.

## NOTE TO READERS

Confidentiality has emerged as a major, persistent ethical challenge for psychologists. Over half (62%) of the therapists in one national study reported unintentionally violating their patients' confidences (Pope et al., 1987). Another national study found that the most frequently reported intentional violation of the law or ethical standards by senior, prominent psychologists involved confidentiality (Pope & Bajt, 1988). In 21% of the cases, therapists violated confidentiality in transgression of law. In another 21% of the cases, therapists refused to breach confidentiality to make legally required reports of child abuse. Therapists may have experienced violations of confidentiality when they themselves were patients. In one national survey, about 10% of the therapists who had been in therapy reported that their own therapist had violated their rights to confidentiality (Pope & Tabachnick, 1994).

As with driving, even a brief lapse of attention can cause a catastrophe. We do the hard work of sorting through the legislation and case law that govern confidentiality and privilege in our local jurisdiction, study the relevant ethics codes and professional guidelines, consult with an attorney, and keep up with the changing standards of care. But somehow our minds wander, our ethical awareness flickers and falters, and we stumble into trouble.

Bemister and Dobson (2011) provide a thoughtful analysis of how “maintaining and protecting the confidentiality of client records has become far more complex in recent years” (p. 302; see also Allan & Allan, 2016; Halovic, 2019; Pope, 2015a). Allen (2009) discusses additional layers of complexity and potential confusion—resulting in additional pitfalls—that variations in the nature of confidential material and the number of people entitled to receive it can cause. She emphasizes that confidential material includes more than facts alone. “Facts, impressions, events, and data of all sorts can be deemed confidential” (p. 127). Similarly, she notes the great range of people to whom the therapist may—or may not—be allowed or obligated to disclose confidential information. “[T]he community

authorized to receive confidential information can be smaller than a family or as large as a workforce” (p. 127; see also Jain & Roberts, 2009).

This chapter highlights some of those easy-to-overlook pitfalls that can lead to violations of confidentiality.

## **REFERRAL SOURCES**

As clinicians, we appreciate referrals to keep our practices going. But there are some key questions that we should consider about our referral sources. For instance, should we tell the referral source whether someone scheduled an appointment with us, whether the person showed up for the appointment, or what might have been discussed or decided if the patient has not authorized the disclosure? Unfortunately, therapists may, without thinking, violate confidentiality by sending referral sources a thank-you note mentioning a specific patient and giving a detail or two about what happened without the patient’s knowledge or consent.

## **PUBLIC CONSULTATION**

Consultation provides an invaluable resource for meeting the highest ethical, legal, and clinical standards. It gives us easy access to new information, support, informal peer review, and a different perspective. Psychologists in a national study rated “consultation with colleagues” as the most effective source of guidance for practice (Pope et al., 1987). They judged such consultation to be more effective than 14 other resources, such as graduate programs, internships, state licensing boards, and continuing education programs.

As valuable as consultation is, we need to keep in mind that consultation about patients deserves the same confidentiality as the psychotherapy it focuses on. We lead busy lives and want to make the most of our time. Often the fastest way to catch a colleague for a quick consultation is while we are walking through the halls of a clinic, or sitting together at a large table while waiting for the last arrivals so that a meeting can begin, or at a restaurant during a lunch break, or in other public places. The problem with such on-the-run

consultations is that confidential information is often discussed within earshot of people who are not authorized to receive the information. Many of us have probably overheard such talk in clinic hallways or elevators. Perhaps we heard the patient's name, someone we recognized as a friend, neighbor, or colleague. In one case, a therapist consulted a colleague on a crowded elevator about a particularly "difficult" patient, unaware that the patient was standing only a few feet behind her, listening carefully. Guarding confidentiality includes making sure that we keep private consultations private.

## **GOSSIP**

Few would argue that therapy is easy work. Sometimes it involves considerable stress, and we need to blow off steam. Talking about our work with others—at lunch, in the staff lounge, on the racquetball court, at parties—may make us feel better. Those settings make it easy to let slip the identity of one of our patients or betray what a patient has told us in confidence.

Some patients may be in the news or tell us fascinating information. The urge to tell others that we know them can be powerful. Many of us may know through the grapevine who is in treatment with whom and even what led them to seek therapy. As interesting as this kind of insider trading of confidences may be, it is also unethical and fails to respect the dignity of the patient and the legal rights that belong to the patient.

## **CASE NOTES AND PATIENT FILES**

Protecting client's personal information extends beyond verbal sharing—it also includes documented, written, and virtual notes and files. Have you ever seen a patient's chart, either printed out or on a computer screen, that you were not authorized to see? It is likely that at least some—if not most—of you have happened to see unsecured documents containing patient names and other confidential information. Some clinics and individuals may have difficulty meeting their responsibility to keep confidential records confidential. During a visit to a prestigious university-affiliated teaching hospital,



one of the authors noticed, while walking down a public hallway, that the mental health clinic's patient charts were stacked along the walls. The hallway was unattended. The names of the patients were clearly visible, and had the author—or anyone else—opened any of the charts, a wealth of confidential information would have been instantly available. When they asked later about charts being left in the hall, they were assured that this was temporary. Due to insufficient funds, additional storage space was not yet available, and this manner of “filing” was the most convenient for the business office personnel. While on hold for a family member's telehealth appointment, another author of this text witnessed a provider talking about their previous patient's diagnosis with their staff before turning their attention to the patient waiting (see also [Chapter 24: Therapists in a Virtual World](#)). What message is this giving to the patient about the clinician's trustworthiness?

## **PHONES, FAXES, AND MESSAGES**

Some of this book's readers may have visited clinics in which phone messages mentioning a patient's name, telephone number, and reason for calling were left out where they could be seen by those who should not see it. Some may have visited a colleague's office just as a fax about a patient was coming in or the computer was printing out a bill or other document, and ... well, just could not help seeing who it was from and what it was about. Some readers may have overheard a therapist take a phone call from a patient and heard both sides of the conversation (and may have been surprised to recognize the patient's voice).

Answering machines and voice mails with speaker phones create special pitfalls for confidentiality. It is tempting, if our time for lunch is limited, to play back accumulated messages—some from patients—while a friend is waiting to accompany us to the nearest restaurant. If our answering machine is at home, we need to make sure that our family, friends, and others do not overhear messages as they are recorded or played back. Again, the Golden Rule can provide a useful guide to anticipating potential problems and recognizing the need to remain constantly mindful, aware, and alert.

## HOME OFFICE

As discussed in prior editions of this book and in *How to Survive and Thrive as a Therapist* (Vasquez, 2005), home offices pose special challenges to confidentiality and privacy. Is it likely that patients—some of whom may not want anyone else to know that they are in psychotherapy—will encounter family members or friends when arriving, waiting for the appointment, or leaving? Any chance that kids will interrupt therapy sessions? Will files, appointment books, message slips, and other documents stay out of sight when family members enter the office? Will family members be able to overhear phone, Zoom, FaceTime, Skype, or other video conferencing sessions with patients? Is confidential information about patients stored on a computer that other family members use? If so, how is it secured against accidental discovery? Is the telephone answering machine that receives calls from or about patients shared with other family members? If so, how can those calls be protected against accidental playback for other family members? Are answering machine messages from or about clients ever played back in the presence of family members? And are answering machines protected so that children cannot accidentally play back the messages?

## SHARING WITH LOVED ONES

Some therapists may hold back no secrets from a spouse, partner, or other loved ones. For some, sharing what happened during the day with a loved one may be a crucial act of intimacy. The ethical challenge is to do this while respecting the client's rights by not violating their confidentiality.

## POST-DEATH CONFIDENTIALITY

Our responsibility to be trustworthy requires us to discuss with patients the role of confidentiality after the patient dies. We may not want to think about death and dying, but as therapists it is important for us to do so. Post-death confidentiality is important and in particular when we are working with clients who are terminally ill.

Generally, the responsibility to maintain confidentiality extends beyond the client's death. Werth et al. (2002) provide a useful clarification statement for us to explain to clients and include in our informed consent form. The following exemplar provides a model we can adapt to help clarify the place of confidentiality on what they call "confidentiality beyond the grave:"

You need to know before you disclose anything to me that, following your death, the executor of your estate may be legally able to obtain information and materials accumulated in the course of this psychotherapy. You and I need to discuss how you would like to proceed regarding highly sensitive material. In addition, you may want to consult with an attorney to request that these materials continue to be confidential following your death (p. 218; see also [Chapter 18](#)).

## **COMMUNICATIONS IN GROUP OR FAMILY THERAPY**

When therapy includes more than one individual, as in group and family therapy, patients have a right to know in advance, as part of the informed consent process, any limitations of privacy, confidentiality, or privilege affected by the presence of more than one patient. For example, if a clinician is providing family therapy, will they keep confidential from other family members information conveyed in a telephone call from a minor son that he is using drugs, from a minor daughter that she is pregnant, from the father that he is engaging in an extramarital affair and plans to leave his partner, or from the mother that she has secretly withdrawn the family's savings and is using it to gamble? What does a psychotherapist need to tell prospective patients about how "secrets" will be handled so that the clients' consent can be informed (see, e.g., Mark & Schuman, 2020; Marks et al., 2019; Turliuc & Candel, 2019)?

Psychotherapy involving more than one patient emphasizes trust, a major theme of this book (see [Chapter 5](#): Trust, Power, Caring, and Healing). The therapist and members of a therapy group may assume that everyone involved is trustworthy. But what if that is wrong? What if a group member is a newspaper or magazine reporter

gathering information for an exposé of what the reporter considers bogus therapy groups, or of the therapist, or of what the reporter considers a “culture of dependency”? Or what if a group member later decides to write a memoir to be published in a magazine or book about what the experience of group therapy was like? Or what if some of the group members simply pass along what they learn about other group members to their family and friends and that information ripples outward to those who recognize and know members of the group? What if group members run into each other at a social gathering or a public setting and one of them discloses that they both are/were in therapy together? Group and family therapists must struggle with these issues in a way that respects the patients’ legitimate rights to privacy, confidentiality, and privilege and their right to know the limits—both legal and practical—of their privacy, confidentiality, and privilege.

Therapy involving more than one person also presents challenges to documentation. If, for example, the therapist keeps one set of therapy records for “the family” or “the group,” what happens if one member of the family or group requests or subpoenas a copy of those records? How can a therapy record that mentions more than one patient by name be turned over without the informed consent or legal waiver of each patient? One approach that some therapists use is to keep a separate chart for each patient in a family or group.

## **WRITTEN CONSENT**

A common problem is failing to obtain written informed consent to release confidential information. As discussed in [Chapter 16: Informed Consent and Informed Refusal](#), both the APA Ethics Code and the CPA Ethics Code address documenting a patient’s consent with either a signed consent form or a note in the record about obtaining consent orally.

Obtaining written consent can help promote clarity of communication between therapist and patient in situations when misunderstandings can be disastrous. Both need to understand exactly what information the therapist will release. Is the therapist free to discuss any aspect of the client’s history, situation, and treatment? Is the therapist authorized to provide a written summary

or all clinical files? When does the client's authorization end? If the person who is to receive the confidential information contacts the therapist with additional questions next month, next year, or several years from now, does the written consent need to be renewed, or does it explicitly cover such future requests?

Patients may not understand the type of information that insurance companies require to authorize coverage and the degree to which information will or will not be sufficiently safeguarded by the insurance company. It is helpful to let patients know that you have no control over what happens to information or documents, or how they are used, once they leave your possession.

## **MANAGED CARE AND OTHER ORGANIZATIONS**

How widely do your therapy reports circulate within managed care and other organizations? Many patients feel betrayed when records of their psychotherapy sessions become part of their general medical or health record in a health maintenance organization (HMO), employee assistance program (EAP), or other organization find their way into other hands. One woman was shocked to find her treatment mentioned on the employee relations bulletin board where she worked. Management and the union, eager to cut both sick leave and the costs for their health-care plan, had decided to post all utilizations of the health-care plan by employees. Under the terms of the contract that had been negotiated by labor and management, the date and reason for each utilization was provided by the health-care organization to officials for both union and management.

From the creation of the first managed care organizations, challenges to confidentiality have grown:

Managed care companies generally ask for much more information than third parties have traditionally requested from clinicians. The ethical explanations given for such requests generally have fallen into two categories. One is based on the known history of some clinicians to distort information on forms .... Then managed care companies began to discover that some clinicians charged for sessions not provided or approved. A more general reason applicable to all clinicians is to make sure that the intended treatment meets criteria of medical necessity as designated in the third-party benefits. In addition to treatment plans, managed care companies will often ask for copies of any notes kept on patients; they sometimes do on-site reviews of charts in hospitals, and on occasion they even talk directly to the patient to try to verify information (Moffic, 1997, p. 97).

Early on, the National Academies of Practice (including dentistry, medicine, nursing, optometry, osteopathic medicine, podiatric medicine, psychology, social work, veterinary medicine, audiology, occupational therapy, physical therapy and speech and language pathology) adopted Ethical Guidelines for Professional Care and Services in a Managed Care Environment (1996). Confidentiality is one of five guidelines listed as a primary concern. While the National Academies of Practice acknowledges that utilization and quality assurance reviews are appropriate functions in a healthcare system, they emphasize the importance of safeguards to protect the privacy and confidentiality of patient data and the practitioner's clinical materials. They state,

The rationale for this position is founded on the patient's autonomous right to control sensitive personal information. It is further based upon an historical recognition in the oath of Hippocrates and corroborated throughout the centuries, of the enduring value of preserving confidentiality in order to enhance mutual trust and respect in the patient-provider relationship (p. 5).

Anne Slowther and Irwin Kleinman (Slowther & Kleinman, 2008) wrote:

The increasing capacity to generate and disseminate information in health care, together with the increasing complexity of healthcare provision, has implications for our understanding of the nature and limits of confidentiality. Development of multidisciplinary healthcare teams raises questions of how much information can be shared within the team, and who is recognized as a team member for this purpose (p. 43).

Healthcare organizations may not always monitor who attends case conferences, and discussions of a patient's condition may be overheard by an inappropriate audience.

Similarly, Anne Ward (2010) discusses “how difficult it can be for teams to keep the psychotherapeutic aspects of confidentiality in mind and how, in the current electronic age, fears can arise that patient records may be circulated more widely than is appropriate” (p. 113).

Electronic medical records (EMRs) pose difficult challenges to confidentiality. In “Electronic Medical Records: Confidentiality Issues in the Time of HIPAA,” Margaret Richards (2009) wrote:

For a psychologist in a major academic or medical institution, the EMR provides unique ethical conflicts of which the psychologist may be unaware. By documenting within the EMR, the psychologist is potentially informing all members of that patient's medical team that this patient is involved in psychological care. While most informed consents discuss the limits of confidentiality, patients may not always realize the information that is being shared and with whom. At a minimum, the psychologist using an EMR is providing information regarding the patient's participation in therapy, dates of appointments, types of services offered, and diagnoses, even if the content of the session is not revealed. Typically, this is the same information that is being provided to insurance companies as a natural part of the billing process since the advent of HIPAA (Freeny (2007). Yet, this may not be information that a client wants his primary care physician to have (p. 553; see also [Chapter 24](#): Therapists in a Virtual World).

Who participates in treatment planning, implementation, and review can be a challenging issue in small towns. In one instance, the chief healthcare administrator proposed a periodic case review of current patients to be conducted by staff psychologists. In this town of fewer than 10,000 people, the psychologists would have known many of the patients in a variety of social and business roles. The patients had not given informed consent for this review. This confidentiality issue is not easily addressed. One solution would be for the administrator to agree to hire a psychologist from another community who did not know the population served by the hospital to visit the hospital once a month to review the cases and make sure that patients understood the review process.

## **DISCLOSING CONFIDENTIAL INFORMATION FOR MANDATED REPORTS ONLY TO THE EXTENT REQUIRED BY LAW**

Evolving legislation and case law in each jurisdiction define the limits of information to reveal in making legally mandated reports. For example, a psychologist was contacted by a mother who wished to arrange appointments for her daughter and her daughter's stepfather to see the therapist regarding allegations that the stepfather engaged in sexual intimacies with his stepdaughter. The psychologist agreed to meet with him and immediately filed a formal report of suspected child abuse.

The next day, a deputy sheriff contacted the psychologist for information. The psychologist provided information about his meeting with the daughter. He would meet with the stepfather later in the day. The deputy called later and asked for information concerning the session with the stepfather and, reading from the Child Abuse Reporting Law, emphasized that the psychologist was obligated to supply additional information, which the psychologist reluctantly provided.

The stepfather claimed in court that the psychologist, after making the initial formal report, should not have disclosed any additional information. The Supreme Court of California agreed with the stepfather:



The psychologist was under no statutory obligation to make a second report concerning the same activity .... We have recognized the contemporary value of the psychiatric [sic] profession, and its potential for the relief of emotional disturbances and of the inevitable tensions produced in our modern, complex society .... That value is bottomed on a confidential relationship; but the doctor can be of assistance only if the patient may freely relate his thoughts and actions, his fears and fantasies, his strengths and weaknesses, in a completely uninhibited manner (*People v. Stritzinger*, 1983, p. 437).

Psychotherapists who disclose confidential information even in court settings may be subject to lawsuits by the client. California, for example, has general legislation protecting individuals from lawsuits for any statements made as part of court proceedings. Nevertheless, a district court of appeals ruled that a psychologist “can be sued for disclosing privileged information in a court proceeding when it violates the patient’s constitutional right of privacy” (Chiang, 1986, p. 1).

## **PUBLISHING CASE STUDIES**

Publishing case studies or other confidential information about patients requires exceptional care. Merely changing the patient’s name and a few other details may not be enough. Pope et al. (1978) discussed a case in New York in which a therapist was successfully sued for publishing a book in which he described his treatment of a patient. The patient asserted that the therapist had not obtained her consent to write about her treatment and had not adequately disguised the presentation of her history.

APA’s Casebook on Ethical Principles of Psychologists (Board of Professional Affairs, Committee of Professional Standards 1988) presents a situation in which a psychologist wished to write a book about an assessment:

Psychologist G conducted a professional evaluation of the accused murderer in a sensational and well-publicized case in which six teenage girls, who vanished over a period of 18 months, were later found stabbed to death in an abandoned waterfront area of the city. The lurid nature of the crimes attracted nationwide publicity, which only increased as allegations of negligence were pressed against the city administration and the police force. In order to construct a psychological diagnostic profile, Psychologist G spent several days with the accused, conducting interviews and psychometric tests. He presented his findings in court with the full consent of the accused. Six months later, following the sentencing of the now convicted murderer, Psychologist G determined that he would like to write a book about the murderer and the psychology behind the crimes, which he anticipated would be a lucrative undertaking. Psychologist G wrote to the Ethics Committee to inquire whether it would be ethical for him to do so. The convicted murderer had refused permission to publish in a book the results of the psychological evaluation, despite the fact that the information was now considered part of the public domain because it had been admitted in court as evidence. Opinion: The Ethics Committee responded to Psychologist G that to write the proposed book would be a legal but unethical undertaking. The fact that material has entered the public domain or that there may have been an implied waiver of consent does not free the psychologist from the obligation under Principle 5.b of the Ethical Principles to obtain prior consent before presenting in a public forum personal information acquired through the course of professional work. In this case, the ethics code sets a higher standard than the law would require. Psychologist G thanked the Committee for its advice and dropped the idea of writing the book (p. 72).

## **DISTRACTION**

Major problems related to violations of confidentiality may happen when we are too busy or not paying attention because we are multitasking or trying to get things done quickly. Momentary distractions can cause lasting problems. No matter how senior our status, how extensive our training, or how naturally skilled any of us

may be, none of us is perfect. All of us have moments when we are tired, overwhelmed, rushing, or careless. James F. Masterson, a prominent therapist who wrote extensively about borderline personality disorders, showed courage in writing about an instance in which he betrayed a patient's confidence because of something that had happened in his own life:

One morning I was late and dented my car as I parked in the office garage. A bit frazzled from the experience, I rushed into my office and admitted my first patient who asked me how another patient of mine was doing, calling her by name. I was startled because their appointments were at very different times. I wondered if they had met socially, or if he was dating her. Then I realized what had happened. Worried about my dented fender, I had inadvertently picked her file out of the drawer instead of his, and he had read her name on the folder. My distraction represented a counter-transferential failure to pay proper attention to my patient. I apologized for taking out the wrong chart and told him I was distracted by the accident (Masterson, 1989, p. 26).

## **FOCUSING ON LEGAL RESPONSIBILITIES TO THE EXCLUSION OF ETHICAL RESPONSIBILITIES**

Our ethical commitment to protecting clients' private information goes beyond our legal responsibilities to do so. Unfortunately, as noted by Fisher (2008), confidentiality workshops often focus on laws and risk management while spending relatively little time on our ethical responsibilities. Fisher describes how HIPAA brought forth the growth of attorney-led HIPAA-compliance training that further overshadowed ethics training in confidentiality. Fisher wrote:

Such legally based training creates several ethical problems for psychologists. First, it fosters the impression that attorneys—not clinicians—have become the only “real” experts about this aspect of practice. Second, it creates a legal language about confidentiality that threatens to usurp psychologists’ own clinical or ethical language about it: Laws take center stage, when what is needed is a language for placing them into ethical context. Third, it exacerbates the figure-ground confusion (by substituting legal rules for ethical rules) and often takes a risk-management perspective that raises anxiety: It encourages psychologists to focus on obeying laws in order to avoid risks to themselves, when what they need is a clearer focus on their ethical obligations and the potential risks to clients. Finally, the legal emphasis obscures an important fact about risk management: Understanding and following the relevant ethical principles is an essential ingredient in avoiding a malpractice suit ....(p. 6).

# SCENARIOS FOR DISCUSSION

As a new client speaks to you via FaceTime, they describe their intense despair and anger at having had a fever when they were tested before being allowed to enter their workplace. Referred for a more extensive testing, they were diagnosed with the novel coronavirus (COVID-19) two days ago, told to stay home and self-isolate, and not to return to work until cleared by the physician. This means being unable to earn income while sick. Boiling over with rage, they've been going maskless while riding busses and subways, trying to infect as many people as possible. No matter what you say, they refuse to stop expressing their rage in this way.

- How do you feel?
- In your jurisdiction, do you have any legal obligation to breach confidentiality in order to report or protect?
- Do you have any ethical obligation to breach confidentiality in order to report or protect?
- What are your options?
- What do you think you would do?

...

You have been working for two years with a patient who has multiple problems and has disclosed extremely sensitive information to you. The insurance company sends you a letter requesting the entire file, including all of your chart notes and all raw data from the psychological assessment, in order to determine whether further therapy is warranted and, if so, in what form. When you call the insurance company to discuss the matter, the head of claims review (not a mental health professional and whose previous job was quality control officer in a paper clip company) tells you that they must have all these materials within five business days or else therapy will be discontinued.

- How do you feel?
- What options do you consider?
- If the patient refuses to provide consent for you to send the materials, even though it means there are no longer resources to pay for the therapy, and decides to terminate therapy rather than allow the information to go to third parties, what do you do?

• • •

You have been working with a 14 year-old patient for several months. During one session, the patient suddenly discloses having sex with a parent for the past four years. The patient, who has been chronically depressed, threatens, “If you tell anyone about this, I will find a way to kill myself.” You believe that this is not an idle threat.

- How do you feel?
- Under what circumstances, if any, do you believe you might disclose information about the client’s claim of having been sexually involved with a parent to any of the following: (a) child protective services or other governmental agency authorized to receive reports of suspected child abuse; (b) your clinical supervisor; (c) any family member; or (d) anyone else?
- What objectives or priorities would shape your interventions?
- To what extent, if at all, would your own potential legal liability affect your emotional responses to this situation and your course of action?

• • •

You are working with a patient who engages in unprotected sex with a variety of partners. Two months ago, the client became infected with HIV. Recent sessions have focused on many topics, one of which is the patient’s decision not to begin using protection during sex and not to disclose the HIV status to any

partners. The client shows no likelihood of changing this decision.

- How do you feel?
- Does the patient's decision affect your ability to empathize in any way?
- Under what conditions, if any, would you act against the patient's wishes and communicate information about the client's HIV status and sexual activity to third parties? What information would you disclose, to whom would you disclose it, and what are the likely or possible outcomes?

• • •

You work for an employee assistance program, spending 4 hours a day, three days a week, providing outpatient therapy at its facility. Four other clinicians provide therapy in the same office. According to program policy, all patient charts of all clinicians using that room must remain locked in a single filing cabinet in the corner of the room. Each clinician has a key to the filing cabinet. You become aware that several of your patients have social relationships with the other therapists. You are also aware that their charts contain extremely sensitive information about them. You also notice the names of two of your friends on the charts of the other clinicians. The employee assistance program refuses to change this policy.

- How do you feel?
- What courses of action do you consider?
- Are the clients entitled to know about this arrangement? If so, at what point should they be made aware of it?
- If you were the client in such a situation, do you believe that you would be entitled to know about this arrangement?

• • •

You have reached a therapeutic impasse with a patient. For weeks, therapy has seemed stalled, but you have not understood why. During the past few supervision sessions, you discovered

that this client has stirred up some intense emotions in you. You've mentioned to your supervisor some painful events in your own history about which you have felt ashamed and confused. You have yet to discuss these events with anyone else, even your own therapist. One afternoon you head to the staff lounge but pause just before entering the room. Through the door, you hear your supervisor talking with others about the painful events you had discussed in supervision.

- How do you feel?
- Which of the following do you think you'd do and why: (a) leave immediately, hoping no one saw you; (b) linger at the door, hoping to hear more; (c) enter the room, pretending that you hadn't heard anything; (d) enter the room and indicate that you had heard what they had said; or (e) something else?
- Under what circumstances, if any, do you believe that clinical supervisors should discuss what their supervisees tell them? In your experience, have these boundaries of confidentiality been explicit and well understood by supervisees and supervisors? In your experience, have supervisors respected these boundaries?
- Have the clinical supervisors you have known or known of kept notes or otherwise documented the supervision sessions? What ethical, legal, or other considerations affect the privacy and confidentiality of supervision notes (for example, are they legally privileged communications)?



# **Chapter 22**

## **RECOGNIZING, ASSESSING, AND RESPONDING TO SUICIDAL RISK**

Working with a patient who has suicidal thoughts or plans can challenge us in many ways, but it also gives us an opportunity to help save a life. The process of helping people through these difficult times can bring weight, worry, and uncertainty to our work. Life or death decisions are on the line. This work can also bring us joy, satisfaction, and a deep sigh of relief when things go well. Other times it can bring shock, numbness, grief, second-guessing, and feelings of guilt and remorse.

Suicide statistics in the United States (US) are stark. For instance, the suicide rate in the US rose to 31% from 2001 to 2017 (Owens et al., 2020). Suicide remains among the top dozen causes of death in the US and Canada, as high as number two for some groups. Homicide rates seize popular attention, but over twice as many people kill themselves as kill others. Experts voice the view that flawed reporting methods cause the reported figures to vastly understate the problem.

Some groups and subgroups face significantly different rates of suicide and attempted suicide than others. The rate of attempted suicide for American Indian and Alaska Native high school students is almost three times that of the general population of high schoolers. In addition, the suicide rate for heterosexual high schoolers is 6.4%, for those unsure is 16.1%, and for lesbian, gay, bisexual (LGBs) teens is 23.4% (Frank, 2020). Some groups face greater risks than they once did. Hempstead and Phillips (2015), for example, report that the US suicide rates for middle-aged men and women started rising in 1999, and in 2007 started a much steeper climb.

The socio-cultural context of the country where people live matters. To illustrate, a meta-analytic review found that the countries with the highest rates of adolescent suicide were Estonia, New Zealand, and Uzbekistan (Glenn et al., 2020).

Assessing and responding to suicidal risk is a source of serious stress for many of us. This part of our work focuses all the complex issues that run through this book: questions of the therapist's influence, competence, efficacy, culture, fallibility, over- or under-involvement, responsibility, and ability to make life-or-death decisions. Litman's study (1965) of over 200 clinicians soon after their patients had committed suicide found the experience to have almost nightmarish quality. Clinicians experienced intense grief, loss, and sometimes depression as anyone—professional or nonprofessional—might feel as a result of living through the death of someone they cared about. But as therapists they also felt guilt, inadequacy, self-blame, and fears that they would be sued, investigated, or vilified in the media. Dransart et al. (2017) found that therapists who have been working with a client who commits suicide “can experience emotional turmoil or disruption, stress reactions ranging from acute stress to post-traumatic stress disorder, or grief and bereavement. They can also doubt their professional judgment, their competence and skills in assessing and supporting suicidal people, and fear legal consequences” (p. 245).

Support from friends, colleagues, and—if needed—a therapist can serve a protective function and lower the risk of negative effects on the therapist's practice (Gulfi et al., 2016). Goldstein and Buongiorno (1984) were among the first to recommend providing support groups for surviving therapists.

Of all mental health professionals, trainees may be among the most vulnerable. On the basis of their study, Leane et al. (2019) identified a patient's suicide as one of the most stressful events for a therapy trainee, one that often causes post-traumatic symptoms and negative professional consequences. Kleespies et al. (1990) found that “trainees with patient suicides reported stress levels equivalent to that found in patient samples with bereavement and higher than that found with professional clinicians who had patient suicides” (p. 257).

They recommend that all training programs create a plan to help trainees with client suicide:

There is a need for an immediate, supportive response to the student to prevent traumatization and minimize isolation ... and ... for a safe forum that will allow the student to express his or her feelings, will ensure positive learning from the experience, and will help the student to integrate it constructively into future work with high-risk patients (p. 262–263).

The challenges of helping a patient who is suicidal can make many of us feel uncomfortable—at least some of the time. It can also show the extraordinary efforts that some therapists take to help their clients stay alive. Some of the examples in this chapter may seem deserving of criticism by some in our profession. Those who use this subset of approaches must understand that they open the therapist to criticism and perhaps formal complaints. Risk management workshops rarely endorse late night telephone calls or going to the home of a patient who is suicidal, to say the least. And yet Gerry Davison, University of Southern California (USC) Professor of Psychology, who served as Chair of the Department of Psychology, Director of the Clinical Training Program, and President of the Association for Advancement of Behavior Therapy, and his co-author, the late John Neale, who was Professor of Psychology at SUNY Stony Brook, described the ways in which “the clinician treating a suicidal person must be prepared to devote more energy and time than he or she usually does even to psychotic patients. Late-night phone calls and visits to the patient’s home may be frequent” (1982).

Bruce Danto, a former director of the Detroit Suicide Prevention Center and former president of the American Association of Suicidology, stated:

With these problems, you can't simply sit back in your chair, stroke your beard and say, "All the work is done right here in my office with my magical ears and tongue." There has to be a time when you shift gears and become an activist. Support may involve helping a patient get a job, attending a graduation or play, visiting a hospital, even making house calls. I would never send somebody to a therapist who has an unlisted phone number. If therapists feel that being available for phone contact is an imposition, then they're in the wrong field or they're treating the wrong patient. They should treat only well people. Once you decide to help somebody, you have to take responsibility down the line (Colt, 1983, p. 50).

Norman Farberow, a preeminent pioneer in helping suicidal clients, described instances in which the therapist provided very frequent and very long sessions (some lasting all day) to a severely suicidal client as

examples of the extraordinary measures which are sometimes required to enable someone to live. Providing this degree of availability to the client gives the client evidence of caring when that caring is absolutely necessary to convince that client that life is both livable and worth living, and nothing less extreme would be effective in communicating the caring. In such circumstances, all other considerations—dependence, transference, countertransference, and so on—become secondary. The overwhelming priority is to help the client stay alive. The secondary issues—put "on hold" during the crisis—can be directly and effectively addressed once the client is in less danger (Farberow, 1985, p. C9).

Stone (1982) describes a vivid example of the lengths to which a therapist can go to communicate caring in an effective and therapeutic manner to a patient in crisis. Suffering from schizophrenia, a young woman who had been hospitalized during a psychotic episode continuously vilified her therapist for "not caring" about her. Without warning, she escaped from the hospital:

The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made great progress in treatment. Later, after making substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the “midnight rescue mission” it was clear, even to her, how concerned and sincere her therapist had been from the beginning (p. 271).

## ASSESSING SUICIDAL RISK

Clinicians may find the following 22 factors useful in assessing suicidal risk. Four qualifications are key. First, the factors are general, and exceptions are frequent. In many instances, two or more factors may interact. For example, being married and being younger, taken as individual factors, tend to be associated with lower risk for suicide. However, married teenagers have historically shown an extremely high suicide rate. Second, these factors are not static. New research enriches our understanding as well as reflects changes. The suicide rate for women, for example, has been increasing, bringing it closer to that for men. Third, the list is far from comprehensive. Fourth, these factors may be useful as guidelines but cannot be applied in an unthinking, mechanical, or conclusive manner. Someone may rank in the lowest-risk category of each factor and still commit suicide. These factors can help us think through a situation but never replace a comprehensive, humane, and personal evaluation of a unique patient’s suicidal risk. Again, it is worth returning to a central theme of this book’s approach to ethical awareness and behavior—perhaps the most frequent threat to ethical behavior is the therapist’s inattention. Making certain that we consider such factors with each patient can help us prevent the ethical lapses that come from neglect.

1. ***Direct verbal warning.*** A direct statement of intention to commit suicide serves as one of the most useful single predictors. Take any such statement seriously. Resist the temptation to

reflexively dismiss such warnings as “a hysterical bid for attention,” “a borderline manipulation,” “a clear expression of negative transference,” “an attempt to provoke the therapist,” or “yet another grab for power in the interpersonal struggle with the therapist.” It may be any or all of those and yet still foreshadow suicide.

2. **Plan.** The presence of a plan increases the risk. The more specific, detailed, lethal, and feasible the plan is, the greater the risk.
3. **Past attempts.** Most suicides are preceded by at least one attempt. Patients who have tried to kill themselves tend to be at increased risk for suicide. In one study, a history of a prior attempt along with the presence of a plan predicted 83% all attempted suicides during the following six weeks (Boudreaux et al., 2018).
4. **Indirect statements and behavioral signs.** People planning to end their lives may communicate their intent indirectly through their words and actions—for example, talking about “going away,” speculating on what death would be like, giving away their most valued possessions, or acquiring lethal instruments.
5. **Depression.** The suicide rate for people who are clinically depressed is 15 to 20 times higher than for the general population. People diagnosed with Major Depressive Disorder (MDD) have a suicide risk rate of around 5% (Orsolini et al., 2020).
6. **Hopelessness.** The sense of hopelessness or the belief that things will not get better appears to be more closely associated with suicidal intent than any other aspect of depression (Beck, 1967; Beck et al., 1975; see also Tsujii et al., 2020).
7. **Alcohol use and abuse.** Alcohol use and abuse are prevalent among those who commit suicide. Connor and Bagge (2019) note that in the US “approximately 36% of male and 29% of female suicide decedents ages 18 and older have a postmortem BAC of 0.001 g/dL or more, and 24% of males and 17% of females have BAC levels that exceed 0.08 g/dL, the US national legal limit for

drinking and driving” (para. 6). A meta-analysis examining the relationship of alcohol use disorder (AUD) and suicide found “a significant association between AUD and suicidal ideation (OR = 1.86; 95% CI: 1.38, 2.35), suicide attempt (OR = 3.13; 95% CI: 2.45, 3.81); and completed suicide (OR = 2.59; 95% CI: 1.95, 3.23 and RR = 1.74; 95% CI: 1.26, 2.21)” (Darvishi et al., 2015).

8. **Marital separation or divorce.** Using the latest US National Longitudinal Mortality Study (NLMS), Kposowa et al. (2020) found that that

when combined, the divorced and separated were over 88% more likely to suicide than the married (ARR = 1.886, CI = 1.649, 2.156). When split, the divorced had suicide risk that was over 97% higher than that of the married (ARR = 1.973, CI = 1.711, 2.274). Separated individuals experienced suicide risk that was nearly 52% greater than that of the married (ARR = 1.515, CI = 1.130, 2.037) (p. 81).

9. **Clinical syndromes.** Those who have clinical syndromes are at increased risk for suicide. “90% of all people who die by suicide have a diagnosable psychiatric disorder at the time of their death” (American Foundation for Suicide Prevention, n.d., p. 4). Depression and alcohol use disorder have already been mentioned. People with schizophrenia have a suicide risk about 20 times as high as the general population, contributing to an estimated 15 years of life lost (Fazel et al., 2019). Bipolar disorder has a suicide rate about 20–30 times that of the general population, the highest of any clinical disorder (Miller & Black, 2020). About 6–7% of people diagnosed with bipolar disorder commit suicide (Carvalho et al., 2020).
10. **Sex.** The male suicide rate is about 3.7 times the female suicide rate (CDC, 2020).
11. **Age.** The CDC (2020) reports that in the most recent array of available data, “Among females, suicide rates ... were highest for those aged 45–64 and lowest for those aged 10–14. Among males, suicide rates were highest for those aged 75 and over and lowest for those aged 10–14” (p. 5).

12. ***Race and ethnicity.*** According to the CDC (2019), the suicide death rates per 100,000 are: 11 for Non-Hispanic American Indian or Alaskan Native, 7.9 for Non-Hispanic Whites, 3.9 for Non-Hispanic Asian or Pacific Islanders, 2.8 for Non-Hispanic Blacks, 2.6 for Hispanics.
13. ***Religion.*** The suicide rates among Protestants tend to be higher than those among Jews and Catholics.
14. ***Living alone.*** The risk of suicide tends to be reduced if someone is not living alone, reduced even more if they are living with a spouse, and reduced even further if there are children.
15. ***Bereavement.*** Bereavement tends to place survivors at increased risk of taking their own lives, even more so if the person is grieving someone who committed suicide (Hamdan et al., 2020). The suicide risk tends to rise around the anniversary of the loss (Rostila et al., 2015).
16. ***Unemployment.*** Unemployment tends to increase the risk for suicide.
17. ***Health status.*** Illness and somatic complaints are associated with increased suicidal risk, as are disturbances in patterns of sleeping and eating (Downward et al., 2020; Fridh et al., 2020). Clinicians who are helping people with HIV or AIDS, for example, need to be particularly sensitive to this risk (Pope & Morin, 1990).
18. ***Impulsivity.*** Those with poor impulse control are at increased risk for taking their own lives (see, e.g., Beckman et al., 2019; Costanza et al., 2020; Rimkeviciene & De Leo, 2015).
19. ***Rigid thinking.*** Individuals who are suicidal often display a rigid, all-or-none way of thinking and problem-solving (Naguy et al., 2020; Yazıhan et al., 2019). A typical statement might be, “If I can’t find a job by the end of the month, the only real alternative is suicide.”
20. ***Stressful events.*** When people are overwhelmed by stressful events, especially when there are serious negative outcomes, the risk for suicide rises.



21. ***Release from hospitalization.*** We sometimes tend to think that we've solved the problem of protecting against suicide when a patient is hospitalized, but a person is at increased risk for suicide when they are released from hospitalization.
22. ***Isolation, lack of a sense of belonging, or loneliness.*** Joiner's review of the research and his own studies led him to conclude that

an unmet need to belong is a contributor to suicidal desire: suicidal individuals may experience interactions that do not satisfy their need to belong (e.g., relationships that are unpleasant, unstable, infrequent, or without proximity) or may not feel connected to others and cared about (2005, p. 97; see also Joiner, 2010).

Appelbaum and Gutheil (2007) focus on the risk factor of

personal isolation, which can derive from a number of sources (for example, immigrants who have not found a local community, those who are retired or unemployed, those living alone, even those living in transient or disorganized areas such as resort towns whose populations fluctuate wildly on a seasonal basis; p. 52).

Courtet et al. (2020) emphasize that "social isolation (such as living alone) and loneliness, defined as a distressing feeling arising from perceived deficiencies in one's social relationships, are strong contributors to suicidal risk" (para. 2; see also Reger, Stanley, & Joiner, 2020).

## **SPECIAL CONSIDERATIONS**

Knowing and understanding the risks of patient suicide creates a special set of responsibilities. The way we handle those responsibilities can have life or death consequences. The following steps may be helpful in handling those responsibilities:

- *Screen all patients for suicidal risk during initial contact and remain alert to this issue throughout the therapy.* Even patients who are seriously thinking of taking their own life may not present the classic picture of agitated depression or the

stereotype of grim determination. Some suicidal patients seem, during initial sessions, calm, composed, and concerned with a seemingly minor presenting problem. Patients who are not suicidal during initial sessions and who started therapy for a minor problem may become suicidal. The rise in suicidal risk may be caused by external events, such as the loss of a loved one or a threat of deportation, or to internal events, such as setting aside psychological defenses or the onset of Alzheimer's disease. What is crucial is an assessment of the patient's suicidal potential at adequate intervals. In some cases, comprehensive psychological testing or the use of standardized scales developed to evaluate suicidal risk may be useful.

- *Check the literature or consult with an expert in this area to see if current research and practice offers any approaches that might be particularly effective with a particular situation or population.*
- *Work with the client to arrange an environment that will not offer easy access to whatever the patient might use to commit suicide.* Suicidal clients who have purchased a gun may agree to place it where they will not have access to it until the crisis is over. Suicidal clients who are currently taking psychotropic or other medication may be planning an overdose. The use of materials prescribed by and associated with mental health professionals may have great symbolic meaning for the patient. Make arrangements so that the patient does not have access to enough medication at one time to carry out a suicidal plan.
- *Work with the patient to create an actively supportive environment.* To what extent can family, friends, and other resources such as community agencies and group or family therapy help a suicidal person through a crisis?
- *While not denying or minimizing the patient's problems and desire to die, also recognize and work with the patient's strengths and desire to live.* Assisting patients to become aware of their strengths, resilience, and reasons to live can often help them regain perspective, often lost during despair.
- *Make every effort to communicate realistic hope.* Discuss practical approaches to the patient's problems.

- *Explore any fantasies the client may have regarding suicide.* Re-evaluating unrealistic beliefs about what suicide will and will not accomplish can be an important step for clients attempting to remain alive.
- *Make sure communications are clear and assess the probable impact of any interventions.* Ambiguous or confusing messages are unlikely to be helpful and can cause considerable harm. The literature documents the hazards of using such techniques as paradoxical intention with suicidal clients. Even well-meant and apparently clear messages may go awry in the stress of crisis. Beck (1967, p. 53) provides an example:

One woman, who was convinced by her therapist that her children needed her even though she believed herself worthless, decided to kill them as well as herself to “spare them the agony of growing up without a mother.” She subsequently followed through with her plan.

- *When considering hospitalization as an option, explore the drawbacks as fully as the benefits, the probable long-term and the immediate effects of this intervention.*
- *Be sensitive to negative reactions to the patient’s behavior.* James Chu (quoted by Colt, 1983, p. 56), a psychiatrist in charge of Codman House at McLean Hospital, a psychiatric hospital near Boston, comments:

When you deal with suicidal people day after day after day, you just get plain tired. You get to the point of feeling, “All right, get it over with.” The potential for fatigue, boredom, and negative transference is so great that we must remain constantly alert for signs that we are beginning to experience them. Maltzberger and Buie discuss therapists’ repression of such feelings. A therapist may glance often at his watch, feel drowsy, or daydream—or rationalize referral, premature termination, or hospitalization just to be rid of the patient. (Many studies have detailed the unintentional abandonment of suicidal patients; in a 1967 review of 32 suicides ... Bloom found “each ... was preceded by rejecting behavior by the therapist.”) Sometimes, in frustration, a therapist will issue an ultimatum. Maltzberger recalls one who, treating a chronic wrist-cutter, just couldn’t stand it, and finally she said, “If you don’t stop that I’ll stop treatment.” The patient did it again. She stopped treatment and the patient killed herself (Colt, 1983, p. 57).

- *Perhaps most important, communicate caring.* Therapists differ in how they attempt to express this caring. A therapist (cited by Colt, 1983) recounts an influential event early in her career:

I had a slasher my first year in the hospital. She kept cutting herself to ribbons—with glass, wire, anything she could get her hands on. Nobody could stop her. The nurses were getting very angry .... I didn’t know what to do, but I was getting very upset. So I went to the director, and in my best Harvard Medical School manner began in a very intellectual way to describe the case. To my horror, I couldn’t go on, and I began to weep. I couldn’t stop. He said, “I think if you showed the patient what you showed me, I think she’d know you cared.” So I did. I told her that I cared, and that it was distressing to me. She stopped. It was an important lesson (p. 60).

One of the most basic aspects of this communication of caring is the therapist’s willingness to listen and take seriously what the patient has to say. Farberow (1985, p. C9) puts it well:

If the person is really trying to communicate how unhappy he is, or his particular problems, then you can recognize that one of the most important things is to be able to hear his message. You'd want to say, "Yes, I hear you. Yes, I recognize that this is a really tough situation. I'll be glad to listen. If I can't do anything, then we'll find someone who can."

## **AVOIDING PITFALLS: ADVICE FROM EXPERTS**

A central theme of this book is that inattention or a lack of awareness is a frequent contributing factor to the violation of our clinical responsibilities and patient trust. We asked prominent therapists with expertise in identifying and responding to suicidal risk to discuss factors that contribute to therapists' inattention or lack of awareness when working with potentially suicidal patients. Their advice, which we share below, can help us save lives.

**The late Norman Farberow, PhD**, was co-founder and former co-director and chief of research at the Los Angeles Suicide Prevention Center. He believed that there are four main problem areas. First, therapists tend to feel uncomfortable with the subject; they find it difficult to explore and investigate suicidal risk: "We don't want to hear about it. We discount it. But any indication of risk or intention must be addressed." Second, we must appreciate that each client is a unique person: "Each person becomes suicidal in his or her own framework. The person's point of view is crucial." Third, we tend to forget the preventive factors: "Clinicians run scared at the thought of suicide. They fail to recognize the true resources." Fourth, we fail to consult: "Outside opinion is invaluable."

**Maryam M. Jernigan-Noesi, PhD**, assistant professor and director of the Intersections Psychology Lab in the Department of Psychology at Agnes Scott College and CEO of Jernigan & Associates Psychological and Educational Consulting, LLC, emphasized:

The increase in suicide rates among People of Color is a silent and growing crisis. We need to sound the alarm and better understand the specific social risk factors that are associated with suicidal thoughts and behaviors among People of Color. Of particular importance are findings indicating that experiences of racial, and other forms of discrimination, are associated with increased odds for suicidal thoughts, plans, and attempts across the lifespan. As therapists, it is important to be aware that in some cases, such experiences are related to *unplanned* suicide attempts and attempts without intent to die. Given the prevalence of racial harassment and discrimination in the lives of People of Color, the implications of such findings underscore the need for therapists to integrate culturally and racially relevant risk factors (e.g., experiences of racial discrimination, racial trauma), into suicide assessment, preventions, and interventions. Be open to listening to the racialized experiences of Clients of Color. Assess reasons for living and dying—when we really listen, our clients will tell us and in turn we may be more effective. Facilitating a positive racial and cultural identity development can serve as a prevention strategy which can buffer the impact of experiences of discrimination for People of Color, thereby enhancing protective factors against the potential for suicidal ideation, behavior or attempts.

**Marsha Linehan, PhD, ABPP**, is a professor of psychology, adjunct professor of psychiatry and behavioral sciences at the University of Washington and director of the Behavioral Research and Therapy Clinic. Her primary research is the development of effective treatments for suicidal behaviors, drug abuse, and borderline personality disorder. She believes that

the single biggest problem in treating suicidal clients is that most therapists have inadequate training and experience in the assessment and treatment of suicidal behaviors. More distressing than that is that there does not appear to be a hue and cry from practicing therapists demanding such training. Deciding to limit one's practice to non-suicidal clients is not a solution because individuals can and do become suicidal after entering treatment. Secondary problems are as follows. (1) Therapists treating clients with disorders that make them high risk for suicide (e.g., depression, borderline personality disorder, bipolar disorder) do not ask about suicide ideation and planning in a routine, frequent way: depending on clients who have decided to kill themselves to first communicate risk directly or indirectly can be a fatal mistake. (2) Fears of legal liability often cloud therapists' abilities to focus on the welfare of the client: fear interferes with good clinical judgment. Many outpatient therapists simply "dump" their suicidal clients onto emergency and inpatient facilities believing that this will absolve them of risk. There is no empirical data that emergency department and/or inpatient treatment reduces suicide risk in the slightest and the available literature could support a hypothesis that it may instead increase suicide risk. (3) Therapists often do not realize that when treating a highly suicidal client they must be available by phone and otherwise after hours: treating a highly suicidal client requires personally involved clinical care.

**David H. Barlow, PhD**, is a diplomate in clinical psychology and founder and director emeritus of the Center for Anxiety and Related Disorders at Boston University. He is a former president of the Society of Clinical Psychology of APA and maintains a private practice. He believes that there are two common problems often encountered in working with young or inexperienced therapists confronting a possible suicidal patient:

First, after forming an alliance with a new patient, some therapists begin to spin away from a professional, objective clinical stance and treat seemingly offhand comments about not wanting to live as casual conversation that might be occurring after work over a drink with a friend or in a college dormitory. Thus, they may respond sympathetically but not professionally by downplaying the report: “Sometimes I feel that way too—I can understand how you’d get to that place.” Of course, one must always step back if this comes up and conduct the proper exam for intent, means, etc., and take appropriate action. Second, some therapists undervalue the power of a contract, since patients sometimes say something like, “Well ... I’ll say that if you want me to, but I don’t know if my word is worth anything.” The fact is, in the context of a good therapeutic relationship, the contract is very powerful, the occasional report to the contrary notwithstanding.

**Judith Lewis Herman, M.D.**, is professor of psychiatry at Harvard University. She is a renowned Traumatic Stress Studies expert and author of the now classic *Trauma and Recovery*, which helped establish the diagnostic category of post-traumatic stress disorder. She is also Co-Founder and Former Director of Training of the Cambridge Health Alliance Victims of Violence Program, Distinguished Life Fellow of the American Psychiatric Association, and the recipient of numerous awards, including the American Medical Women’s Association Award and the International Society for Traumatic Stress Studies Lifetime Achievement Award. She told us that



When a patient tells you she is feeling suicidal, the first thing to recognize is that she is conflicted about it. If she weren't, she wouldn't be in your office. Your job as a therapist is to explore and empathize with both sides of the conflict. First, always express compassion and understanding for the patient's suffering, recognizing that she must be in extreme pain. Then, explore the fantasies of what suicide will accomplish: the famous triad of Relief, Revenge, and Reunion. Only after you fully understand what is driving the wish for suicide would I turn to the other side of the conflict and explore what keeps the patient connected to life. In particular, one searches for attachments to other living creatures. Most people, even very isolated people will be able to evoke some relationship that they care about. Sometimes it's a pet. If there is no one, or if the only caring relationships the patient can evoke is with someone who is dead, the situation is ominous.

As therapists we ultimately have to come down on the side of life. But particularly with patients in a well-established therapy relationship, it's okay for us to share our own conflicts and dilemmas. I will never forget a chronically suicidal patient of mine with a horrible childhood abuse history who at one point signed herself into a hospital when she was feeling suicidal, only to give her notice for discharge, even though she confided in me that she still had an active suicide plan. I tried to persuade her to stay, based on all the arguments I could think of, but she was still adamant. Finally, in exasperation, I burst out "This is completely unfair to me! You're putting me in an impossible situation! If I commit you I'm exerting power over you and that will feel abusive. If I don't, I'm ignoring the situation and that will feel like neglect." The patient immediately understood and agreed to stay in the hospital. She lived and ultimately found a reason for living by adopting her sister's neglected children, determined to end the cycle of abuse in her family.

**Nadine J. Kaslow, PhD, ABPP**, professor and chief psychologist at Emory School of Medicine, a well-funded researcher on the assessment and treatment of abused and suicidal African American women, the recipient of the American Psychological Association's 2004 award for Distinguished Contributions to Education and

Training, and a former American Psychological Association president told us that

assessment and intervention of suicidal persons need to be culturally competent, gender sensitive, and developmentally informed. Our approach to suicidal individuals needs to consider both the relevant evidence base and sensitive attention to the person's unique struggles, strengths, and sociocultural context. We need to interact with suicidal people with compassion and a desire to understand why their pain feels so intolerable that they believe that suicide will offer the only form of relief. It is always important to take suicidal concerns seriously, convey an appreciation for the person's plight, and engage in a collaborative process. Since suicidal people often feel socially isolated and social support is a buffer against suicidal behavior, it is imperative that we assist suicidal men and women in mobilizing their social support networks. We must build on people's strengths, help them find meaning and hope, and empower them to overcome the trials and tribulations that lead them to feel and think that life is not worth living. As therapists, we will find our own countertransference reactions to be a very useful guide with regard to risk assessment, disposition planning, and the implementation of therapeutic strategies. Our own histories with suicide, whether that be our own suicidality, the loss of a loved one to suicide, or the death of a former patient to suicide, will greatly impact how we approach and respond to people who think actively about suicide, take steps to end their own life, or actually kill themselves. Our histories and reactions can also be instrumental in our efforts to help suicidal people heal from their pain so that they find life worth living. This in turn, enriches our own lives.

***Ricardo F. Muñoz, PhD***, is distinguished professor of clinical psychology at Palo Alto University and served as principal investigator on the Depression Prevention Research Project involving English, Spanish, and Chinese speaking populations, funded by the National Institute of Mental Health (NIMH). Here are his thoughts:

First, clinicians often fail to identify what suicidal clients have that they care about, that they are responsible for, that they can live for. Include animals, campaigns, projects, religious values. Second, inexperienced liberal therapists in particular may fall into the trap of attempting to work out their philosophy regarding the right to die and the rationality or reasonableness of suicide while they are working with a client who is at critical risk. These issues demand careful consideration but postponing them until the heat of crisis benefits no one. In the same way that we try to convince clients that the darkest hour of a severe depressive episode is not a good time to decide whether to live or die, clinicians must accept that while attempting to keep a seriously suicidal person alive is not a good time to decide complex philosophical questions. Third, don't overestimate your ability to speak someone else's language. Recently, a Spanish-speaking woman, suicidal, came to the emergency room talking of pills. The physician, who spoke limited Spanish, obtained what he thought was her promise not to attempt suicide and sent her back to her halfway house. It was later discovered that she'd been saying that she'd already taken a lethal dose of pills and was trying to get help.

***Jessica Henderson Daniel, PhD, ABPP***, associate professor of psychology in Harvard Medical Center, director of training in psychology in the Department of Psychiatry, associate director of the Leadership Education in Adolescent Health Training Program in the Division of Adolescent Medicine at Boston's Children's Hospital, and a former American Psychological Association president, told us:

As some adolescents can be prone to be dramatic, that is, saying things that they do not mean, there can be a reluctance to take comments about suicide seriously. The adolescent may make several statements before actually engaging in suicidal behavior. The adolescent needs to know that such comments are in fact taken seriously and that action may be taken: follow-up by their therapist, evaluation in the emergency room, and/or in-patient hospitalization. Also, adolescents can become very upset about matters that may seem trivial to adults. Providers are reminded that the perspective of the patient trumps their views. When adolescents are in the midst of despair, minimizing the worry, hurt, and hopelessness can be problematic. Some providers may feel that life really cannot be that bad. Then, parents matter. With adolescents, state regulations can determine the legal role of parents. It is important to know this information. Should parents be legally responsible for their adolescent, providers may be reluctant to override the decision of parents who cannot bear to think that their child may be suicidal and who insist on taking them home. When the patient is a child or an adolescent, the parents are a critical part of the management of the case and may need their own providers as well. Finally, consultation is critical in thinking through how to best provide under the particular circumstances.

***Danny Brom, PhD***, is director of Metiv, the Israel Psychotrauma Center. The mission of his community-based trauma center is to develop and test new methods of intervention for mitigating the effects of trauma on children and adults. His latest book, with Pat-Horenczyk and Ford, is *Helping Children Cope With Trauma: Individual, Family and Community Perspectives* (Routledge, 2014). He told us:

The client that taught me this lesson had been abused in ways that I had not heard about before and have rarely heard about after. Tortured, abused, made totally dependent and helpless. She suffered from DID. During the course of a long therapy she would become suicidal. When we discussed suicidality, I wanted to have a clear understanding with her that she would call me first if she would feel that she was going to commit suicide. She then made it very clear to me that suicide for her had been and still was her only access to real freedom. If I would take that away from her or block that way by insisting on a contract, she felt that then she really would have to commit suicide. The freedom to commit suicide gave her the freedom to live.

***Shweta Sharma, PsyD*** is an assistant professor of psychiatry in the Menninger Department of Psychiatry and Behavioral Science at Baylor College of Medicine. She is a senior staff psychologist at The Menninger Clinic and a clinical candidate in adult studies in psychoanalysis at the Center for Psychoanalytic Studies in Houston, Texas. Her clinical work focuses on the assessment and treatment of young adults. Here are her thoughts:

Most struggles that patients bring to therapy tend to move us to empathy. Suicidality, instead, often moves us to fear among other emotions (e.g., anxiety, avoidance, helplessness, hopelessness, defensiveness, contempt, disdain, hostility). In our anxiety we rush urgently to find ways to keep the patient alive—trying to talk our patients out of suicide by providing encouragement and instilling hope, trying to strengthen the treatment plan and increase treatment adherence, implementing no-harm contracts, trying to mitigate modifiable risk factors like access to firearms. These practices are all in good faith and well-intentioned. However, I would propose that our frenzied activity to keep the patient alive may also be a way to stop ourselves from feeling and thinking—perhaps to avoid responsibility for our own destructiveness. If this is the case then our core challenge in working with suicidal patients may be learning to manage our emotional reactivity so that we can listen, understand, and empathize with the patient’s suicidal wish (to kill, die, or be dead) while maintaining a life affirming stance. It’s not an easy task and I recommend that we don’t try to do this work alone! In terms of treatment for the problem of suicide, I highly recommend Jobes’ *Collaborative Assessment and Management of Suicidality* (CAMS) approach. Ethically, we must take care of ourselves and strive to be aware of the impact of our own physical and mental health on our ability to help our patients. Consultation, team support, personal therapy and self-analysis can provide the necessary framework for listening and responding authentically in these crises.

**M. David Rudd, PhD, ABPP**, is provost and distinguished university professor at the University of Memphis. He served as president of the American Association of Suicidology and as consultant to the US Army, the US Air Force, the Beijing Suicide Prevention and Research Center, and other organizations. He told us:

One of the all-too-frequently neglected areas in suicide risk assessment is recognizing, discussing, and implementing a distinction between acute and chronic risk. Assessment of acute risk alone is how the overwhelming majority of clinicians approach the task. Over the past decade, converging scientific evidence suggests it is important to address enduring or “chronic” suicidality in patients. More specifically, those who have made two or more suicide attempts likely have a “chronic” aspect to their presentation. Although acute risk may well resolve, it is important for the clinician to make a note about the individual’s enduring vulnerabilities and continuing suicide risk. It’s as straightforward as making a note such as: “Although acute risk has resolved, the patient has made three previous suicide attempts and there are aspects of the clinical scenario that suggest chronic risk for suicide. More specifically, the patient’s history of previous sexual abuse, episodic alcohol and cannabis abuse, along with two previous major depressive episodes, all indicate the need for longer-term and continuing care in order to more effectively treat these chronic markers of risk.”

***Rosa E. Garcia-Peltoniemi, PhD***, is staff clinical psychologist and senior consulting clinician at the Center for Victims of Torture. For the past 33 years she has been at the forefront of developing clinical services for refugees and asylum seekers who have suffered torture at the hands of foreign government both in the US and internationally. Here is what she states regarding specific issues in treating survivors of torture in this country:

For torture survivor clients trying to obtain asylum in the US, adverse decisions carrying the risk of deportation to the very countries in which they were tortured are frequently times of increased suicidal risk. The prospect of being sent back becomes not only very frightening but also an intolerable repetition of a past that was already extremely costly to escape. It is not unusual for torture survivors in these situations to say that they would rather die by their own means than return to their countries and be tortured again. Even less drastic immigration outcomes such as being put on an ankle brace electronic monitor, a practice that has become increasingly common, can carry an increased risk of suicide for torture survivors. Diagnoses of illnesses perceived as terminal or to bring shame (e.g., HIV/AIDS) are also triggers for suicidal ideation in torture survivors; chronic, debilitating illnesses preventing the survivor from taking care of important obligations such as providing or caring for family members often lead to suicidal thinking based on the belief that loved ones would not be burdened, would be better off, happy, etc., following their deaths. Interpersonal losses, particularly the death of parents and children left behind in the country of origin, but also through divorce or abandonment, also tend to be triggers for suicidal risk amongst torture survivors. Many survivors from various different cultures have stated that they don't talk about problems unless they are asked; to talk about suicide carries an even higher burden due to cultural proscriptions for some or simply because of the belief that the rest of the community is also suffering in various different ways. Finding ways to give survivors permission to say how they are feeling then becomes extremely important for clinicians and includes knowing culturally sensitive ways to ask about suicidal ideation. Consultation with knowledgeable cultural providers is a must. Finally, it is important to keep in mind that many torture survivors have suffered traumatic brain injury which may lead to less predictable responses to psychiatric medications, increased risk for adverse outcomes, and an overall requirement of close collaboration across disciplines.

The late ***Erika Fromm, PhD***, a diplomate in both clinical psychology and clinical hypnosis, was professor emeritus of psychology at the University of Chicago, clinical editor of the *Journal*



*of Clinical and Experimental Hypnosis*, and recipient of the American Psychological Association Division 39 (Psychoanalysis) 1985 Award for Distinguished Contributions to the Field. She stated:

Perhaps it's the countertransference or the highly stressful nature of this work, but some clinicians seem reluctant to provide suicidal patients anything more than minimal reassurance. We need to realize that the people who are about to take their own lives are crying out, are communicating their feelings that no one really cares about them. They are crying, in the only way they know how: "Show me that you really care!" It is so important for us to communicate that we care about them. When my patients are suicidal, I tell them that I care deeply about them and am fond of them. I do everything I can to let them know this.

**Gary Schoener**, a clinical psychologist and executive director emeritus of the Walk-In Counseling Center in Minneapolis, consults, trains, and testifies around North America concerning professional boundaries and clinical supervision. He told us:

Four most common deadly failures are (1) the failure to screen for the possession of firearms (it's not enough to ask about "weapons") with all distressed clients; (2) when acute suicidality becomes chronic, failure to appropriately refer to a DBT [dialectic behavior therapy] program or qualified provider for cases of chronic suicidality; (3) reliance on the QPR [question, persuade, refer] method with refugees and others, especially Muslims, for whom suicide is a serious sin and who should not be asked directly about suicidal thinking; and (4) overreliance on "no-suicide agreements" despite the fact that they do not work. (No problem in using them clinically, but don't count on them.)

**Marla C. Craig, PhD**, is a psychologist and clinical director at the University of Texas Counseling and Mental Health Center in Austin, Texas. She has previously worked as instructor and coordinator of a campus-wide suicide prevention program at St. Edward's University. She reported:

Most clinicians may not know that suicide is the second leading cause of death among college students. This information is important since there may be a tendency for clinicians not to take college students' presenting concerns seriously enough. Presenting concerns such as academic and relationship difficulties may mask the underlying condition of depression. Also, stereotypes of college students' being overly dramatic and emotional with fluctuating moods and situations can interfere with a clinician's judgment to thoroughly assess for suicide. It also may be easy for clinicians to forget that traditional college students are still adolescents transitioning into young adulthood, and they may or may not be able to verbally identify what is going on internally/emotionally. Hence, it is important to assess for suicide even if the college student does not present as depressed. Finally, due to confidentiality and college students being eighteen years of age and older, clinicians may be reluctant to get parents involved. If the parents are a source of support, do not hesitate to work with the college student to get them involved.

**Chris Brownson, PhD**, is an associate vice president for student affairs, director of the Counseling and Mental Health Center, a clinical associate professor in Counseling Psychology, and the director of the National Research Consortium of Counseling Centers in Higher Education at the University of Texas at Austin. He advises that

It can be easier than you might think for clients and clinicians to collude around not talking honestly about suicide. Clients might not want to burden their therapists, know that their revelation could cause their therapist distress, worry that their clinician won't care or take them seriously, fear being hospitalized or facing other consequences, or might be concerned that their suicidal plans would be interrupted. Over half of college students in suicidal crisis never tell anyone that they are suicidal, and those that do disclose this to others typically tell a peer. Less often college students reveal their suicidality to a family member, and infrequently might disclose their suicidal crisis to a professional, which is more of a function of an overall lack of help-seeking. Clinicians can compound client reluctance to disclose by sending subtle cues that they would prefer to hear that their clients are not suicidal. Clinicians are aware that a suicidal client will take more time, could be frustrating, might require hospitalization, or might indicate that the therapy isn't going as well as they thought. Clinicians must avoid sending any cues that might inhibit full disclosure, take into consideration relevant demographic and risk factors in their evaluation and assessment in addition to the verbal report of their client, consider the motivations that a client might have to withhold the true nature of their suicidal crisis and appropriately probe around these motivations, and consider not just the client's current report but also their past behavior and history of disclosure before past suicide attempts.

**Jesse Geller, PhD**, formerly director of the Yale University Psychological Services Clinic and director of the Psychotherapy Division of the Connecticut Mental Health Center, currently maintains an independent practice. He told us:

One of the two main problems in treating suicidal patients is our own anger and defensiveness when confronted by someone who does not respond positively—and perhaps appreciatively—to our therapeutic efforts. It can stir up very primitive and childish feelings in us—we can start to feel vengeful, withholding, and spiteful. The key is to become aware of these potential reactions and not to act them out in our relationship with the patient. The other main problem seems to be more prevalent among beginning therapists. When we are inexperienced, we may be very cowardly regarding the mention of suicide in our initial interviews. We passively wait for the patient to raise the subject and we may unconsciously communicate that the subject is “taboo.” If the subject does come up, we avoid using “hot” language such as “murder yourself” or “blow your brains out.” Our avoidance of clear and direct communication, our clinging to euphemisms implies to the patient that we are unable to cope with his or her destructive impulses.

***Danny Wedding, PhD, MPH***, retired from the School of Medicine, University of Missouri, Columbia and now lives in Berkeley, California. Danny has completed Fulbright Fellowships in Thailand and South Korea, and he has lectured widely on suicide prevention. He is especially concerned about the growing problem of adolescent suicide in Asian countries. He notes

Suicide is a serious public health problem, and about a million people die by suicide each year—more than are lost to either homicide or war. Prevalence, methods, and risk factors vary widely across cultures and ethnic groups, and clinicians need to be sensitive to these cultural differences. For example, suicide by pesticide poisoning is common in China and Sri Lanka but rare in Thailand, and suicide rates among American Indian/Alaskan Native adolescents and young adults in the United States are about twice the national average. However, there are also commonalities across cultures—e.g., we know that glamorized media portrayal of suicide can lead to a contagion effect in almost every country. The growing access to the internet found in almost all developing countries poses special challenges (especially cyber bullying) for those of us interested in suicide prevention. Some of the techniques that have been shown to be effective in preventing youth suicide in other countries include screening, gatekeeper training, crisis hotlines, media education and skills training.

***Don Hiroto, PhD***, has maintained an independent practice for over 35 years while also teaching and supervising future psychologists at UCLA. He was chief of the Depression Research Laboratory at the Brentwood Veterans Administration Medical Center, and is a former president of the Los Angeles Society of Clinical Psychologists. He believes that a major area of difficulty involves alcohol use:

Alcoholics may constitute the highest-risk group for violent death. The potential for suicide among alcoholics is extraordinarily high. At least 85 percent of completed suicides show the presence of at least some level of alcohol in their blood. There are two aspects to the problem for the clinician. First, there is the tendency for us to deny or minimize alcohol consumption as an issue when we assess all of our clients. Second, we are not sufficiently alert to the suicidal risk factors that are especially associated with alcoholics: episodic drinking, impulsivity, increased stress in relationships (especially separation), alienation, and the sense of helplessness.

The late ***Helen Block Lewis, PhD***, was a diplomate in clinical psychology who maintained a private practice in New York and Connecticut; she also was professor emeritus at Yale University,

president of the American Psychological Association Division of Psychoanalysis, and editor of Psychoanalytic Psychology. She believed that therapists tend to pay insufficient attention to the shame and guilt their clients experience. For example, clients may experience a sense of shame for needing psychotherapy and for being “needy” in regard to the therapist. The shame often leads to rage, which in turn leads to guilt because the client is not sure if the rage is justified. According to Lewis, the resultant “shame/rage” or “humiliated fury” can be a major factor in client suicides:

Clients may experience this progression of shame-rage-guilt in many aspects of their lives. It is important for the therapist to help the client understand the sequence not only as it might be related to a current incident “out there” but also as it occurs in the session. Furthermore, it is helpful for clients who are in a frenzied suicidal state to understand that the experience of shame and guilt may represent their attempt to maintain attachments to important people in their lives. Understanding these sequences is important not only for the client but also for the therapist. It is essential that we maintain good feelings for our clients. Sometimes this is difficult when the client is furious, suicidal, and acting out. Our understanding that such feelings and behaviors by a client represent desperate attempts to maintain a connection can help us as therapists to function effectively and remain in touch with our genuine caring for the client.

## **ASSISTED DYING—ASSISTED SUICIDE**

While working with clients that are suicidal poses many challenges, we have guidelines that help us assess and manage patients at risk for suicide. However, there is less information on what to do when working with a client who is considering assisted dying, also known as assisted suicide, and aid-in-dying. In the US, assisted dying continues to be illegal in most states. As of 2020, there were eight states (California, Colorado, Hawaii, Maine, New Jersey, Oregon, Vermont, Washington) and the District of Columbia that have legal statutes for safeguarding assisted dying,

Where do you stand on the issue of assisted dying? Are you supporter of assisted suicide? Consider the following scenario: Your

client, with whom you have worked for the past two years, shares that they are terminally ill. According to the client and their treating physician, they only have 4 to 6 months to live. Your client states that they are considering assisted dying. Would you support them through this process? If so, under what conditions? Are you aware of your ethical responsibilities as a psychologist working with this patient? What does the law say about assisted dying in the state where you practice?

When working with a client who is seeking assisted dying, we may face a moral dilemma in the tension between our roles as therapists and our ethical obligation to do no harm. It is difficult to determine whether helping the client to stay alive would cause them harm or whether supporting their decision to go through the process of assisted dying is harmful to the patient. Johnson et al. (2014) wrote:

Individual psychologists possess considerable freedom of choice in regard to duties and involvement in physician assisted suicide. Werth and colleagues (2009) suggested there are no unique professional or ethical considerations for a psychologist working with a patient making end-of-life decisions beyond the ethical concerns present with any client, but our position is that the ambiguously defined and potentially dynamic role could give rise to complex ethical dilemmas. One could construe the participation of psychologists as a violation of Standard 3.04 *Avoid Harm* in the American Psychological Association Ethics Code; after all, psychologists are typically required to intervene in cases of suicidal crises. As APA has no official opinion regarding the involvement of psychologists in PAS, psychologists should carefully consider whether participation would violate their professional responsibility to avoid harm. If upon self-reflection the psychologist feels that participation would violate personal or professional ethics and impair objectivity, he or she must decline the task according to Standard 3.06 *Conflict of Interest* (p. 584–585).

In our roles as supervisors and educators of therapists-in-training, we have found it fruitful to help trainees think through the ethical and moral complexities inherent in the topic of assisted suicide. One way we do this is by asking our students to watch *The Suicide Tourist*

(Zaritsky, 2007), a powerful documentary on the journey of Craig Ewert, native of Chicago living with Amyotrophic Lateral Sclerosis (ALS). Craig makes the decision of going through the process of assisted dying. We instruct our students to pay attention to their emotional reactions and to consider the following questions: What would you do if you were Craig? Imagine Craig is your client, how would you go about assessing and navigating through the process of supporting or not supporting Craig and his decision to undergo assisted dying? After the film, we invite our trainees to discuss whether their perspectives on assisted dying have changed or remained the same. We ask the group to share how their personal perspectives may impact their clinical work with clients who may be considering assisted dying as an option. We invite you to take some time, watch the documentary, and consider your own personal and professional perspectives on assisted dying.

■ ■ ■



# SCENARIOS FOR DISCUSSION

You have been working with a moderately depressed client for five months. You feel that you have a good rapport, but the treatment plan does not seem to be doing much good. Between sessions, you check your answering machine and find this message from the patient: "I want to thank you for trying to help me, but now I realize that nothing will do me any good. I won't be seeing you or anyone else ever again. I've left home and won't be returning. I didn't leave any notes because there really isn't anything to say. Thank you again for trying to help. Good-bye." Your next patient is scheduled to see you in two minutes, and you have patients scheduled for the next four hours.

- What feelings do you experience?
- What do you want to do?
- What are your options?
- What do you think you would do?
- If there are things that you want to do but don't do, why do you reject these options?
- What do you believe that your ethical and legal obligations are? Are there any contradictions between your legal responsibilities and constraints and what you believe is ethical?
- To what extent do you believe that your education and training have prepared you to deal with this situation?

You have been working with a patient while the insurance company is looking over your shoulder. You believe that the patient is at considerable risk for suicide. The case reviewer disagrees and, noting that the approved number of sessions have been provided, declines, despite your persistent protests, to approve any additional sessions.

- How do you feel?

- What are your options?
- What do you believe your legal obligations to client are?
- What do you believe your ethical responsibilities to the client are?
- What would you do?

You have been providing family therapy to a mother and father and their three adolescents for four sessions. After the fourth session, you find that one of the adolescents has left a note on your desk. Here is what the note says: “My father has molested me for the past two years. He has threatened to kill my mother and me if anyone else finds out. I could not take it if you told anyone else. If you do, I will find a way to kill myself.” Your clinical judgment, based on what you have learned during the course of the four sessions, is that the adolescent is extremely likely to commit suicide under those circumstances.

- How do you feel?
- More specifically, what are your feelings about the patient who left you the note? What are your feelings about the father? What are your feelings about the mother? What are your feelings about the other two adolescents?
- What do you believe that your legal obligations are?
- What do you believe that your ethical responsibilities are?
- What, if any, conflicts do you experience? How do you go about considering and deciding what to do about these conflicts?
- What do you believe that you would do?

A patient you have been seeing in outpatient psychotherapy for two years does not respond to the Zoom invitation for their scheduled appointment. The patient has been depressed and has recently experienced some personal and occupational disappointments, but the risk of suicide as you have assessed it has remained at a very low level. You call the patient at home to see if there is a problem with their computer or internet

connection, this person has forgotten the appointment, or if there has been a mix-up in scheduling. You reach a family member, who tells you that the patient has committed suicide.

- What do you feel?
- Are there any feelings that are difficult to identify or put into words?
- What options do you consider?
- Do you tell the family member that you were the person's therapist? Why or why not? What, if anything, do you volunteer to tell the family?
- Do you send flowers? Why or why not? Do you attend the funeral? Why or why not?
- If a family member says that the suicide must have been your fault, what do you feel? What would you do?
- Do you tell any of your friends or colleagues? Why? What concerns, if any, do you have?
- Do your case notes and documentation show your failure to assess accurately the patient's suicidal risk? Why or why not? Do you have any concerns about your documentation?

You have been discussing a new patient, whom you have seen for three Facetime sessions, with your clinical supervisor and the chief of outpatient services. The chief of services strongly believes that the patient is at substantial risk for suicide, but the clinical supervisor believes just as strongly that there is no real risk. You are caught in the middle, trying to create a treatment plan that makes sense in the light of the conflicting views of the two people to whom you report. One morning you arrive at work and are informed that your clinical supervisor has committed suicide.

- What do you feel?
- Are there any feelings that are particularly difficult to identify, acknowledge, or articulate?
- How, if at all, do you believe that this might influence your work with any of your patients?

- Assume that at the first session, you obtained the patient's written informed consent for the work to be discussed with this particular clinical supervisor who has been countersigning the patient's chart notes. What, if anything, do you tell the patient about the supervisor's suicide or the fact that the clinical work will now be discussed with a new supervisor?
- To what extent has your graduate training and internship addressed issues of clinicians' own suicidal ideation, impulses, or behaviors?

You have been working with a Black male client with a long history of racial trauma. During the last session he states losing all hope that things will ever get better in this country. He describes "falling into a big, deep hole, and unable to get out." Your client mentions how things are not only not getting better, but actually getting worse, and that he cannot take it anymore. You listen and affirm him. Your client seems to respond well to your interventions; however, right before the end of the session, you decided to directly ask about suicidal thoughts and your client responds, "because of my religion I know I cannot do anything to harm myself, but I know the police would be happy to help me".

- What are you thinking?
- What are you feeling?
- How would you respond to your client?
- What are some options for what you can do?

# Chapter 23

## SUPPORTING HUMAN RIGHTS AND ADDRESSING OPPRESSION IN PSYCHOTHERAPY

Human rights are those basic inalienable rights belonging to all people regardless of race, ethnicity, gender, sexual orientation, religion, age, ability, or any other factors. They are inherent in all of us simply because we are human. The United Nations affirmed these rights in 1948, publishing the *Universal Declaration of Human Rights* (UDHR). This historic document, drafted by representatives from different countries, defines basic human rights as the freedom, justice, inherent dignity, and equal and inalienable entitlements of all members of the human family (United Nations, 1948).

Human rights live at the core of the work we do as therapists. The values of justice, dignity, and respect are etched into our ethics codes as compasses that guide us toward the profession's highest ethical ideals and practices—that is, to benefit and not to harm those we serve. Principle-A, beneficence and nonmaleficence of the 2017 APA Ethics Code states that

Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons, and the welfare of animal subjects of research (p. 3).

Principle-D of the APA Ethics Code underscores the importance of justice and equity by encouraging

Psychologists [to] recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists. Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices (2017a, p. 4).

Principle-E of the APA Ethics code affirms respect for people's rights and dignity, stating

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices(2017a, p. 4).

Similarly, the 2017 CPA, Principle-I, emphasizes *Respect for the Dignity of Persons and Peoples* by stating that

This principle, with its emphasis on inherent worth, non-discrimination, moral rights, distributive, social and natural justice, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger of bodily harm to someone (p. 4).

In countries outside of the Americas, psychologists have also come to underscore the importance of respecting and protecting human rights in our profession. For instance, in 2008 the International Union of Psychological Science (IUPS) adopted the *Universal Declaration of Ethical Principles for Psychologists* which call on psychologists across the globe to make a commitment to “placing the welfare of society and its members above the self-interest of the discipline and its members” (IUPS, 2008, para. 1). The declaration “reaffirms the commitment of the psychology community to help build a better world where peace, freedom, responsibility, justice, humanity, and morality prevail” (IUPS, 2008, para. 4). In [Table 23.1](#), we list and describe the four

universal ethical principles for psychologists and provide actionable exemplars.

**Table 23.1.** Universal Declaration of Ethical Principles for Psychologists and Actionable Exemplars.

Ethical Principles	Description	Actionable Exemplars
I. Respect for the Dignity of Persons and Peoples	<ul style="list-style-type: none"><li>– All human beings are inherently worthy of respect, dignity, and moral consideration.</li><li>– Differences in race, ethnicity, culture, gender, national origin, sexual orientation, ability status, religion/faith/spirituality , age, and language are core components of peoples’ identities and give meaning to their lives.</li></ul>	<ul style="list-style-type: none"><li>– Provide informed consent in the client’s preferred language—use culturally syntonc language (consider connotations) that is free of academic and legal verbiage.</li><li>– Learn about the history, traditions, beliefs, and values of the social groups your client belongs to and identifies with.</li><li>– Align treatment goals to clients’ cultural values and include them in the treatment planning process.</li><li>– Affirm and validate clients’ reactions to oppression.</li></ul>

Ethical Principles	Description	Actionable Exemplars
<b>II. Competent Caring for the Well-Being of Persons and Peoples</b>	<ul style="list-style-type: none"> <li>– Providing psychological services that improve people’s lives and do no harm.</li> <li>– Developing awareness on how cultural values and personal experiences influence people’s behaviors and mental processes.</li> </ul>	<ul style="list-style-type: none"> <li>– Use knowledge and skills that are culturally responsive (e.g., culturally adapted treatments), racially conscious (e.g., healing race-based stress and trauma), gender inclusive, queer affirming therapies, and respectful of clients’ religion/faith/spirituality .</li> <li>– Address the effects of racism, anti-Semitism, and other forms of oppression on presenting problems and integrate them into an actionable treatment plan.</li> <li>– Help clients to not self-blame and instead help them externalize their oppression—in other words, put the onus on the institutions and systems that create and maintain oppression.</li> </ul>



Ethical Principles	Description	Actionable Exemplars
<b>III. Integrity</b>	<ul style="list-style-type: none"> <li>– The public’s confidence in the profession is built upon honest, truthful, and open communication.</li> <li>– Acknowledging, monitoring, and addressing biases and conflicts of interest that caused or may inflict harm to people.</li> <li>– Being mindful of protecting safety, confidentiality, and respect for cultural differences when disclosing information.</li> </ul>	<ul style="list-style-type: none"> <li>– Demonstrate a commitment to valuing transparency. Provide accurate information about services, how therapy works, limits of confidentiality, and who has access to health records.</li> <li>– Follow through with promises made to clients even if it takes extra time and effort.</li> <li>– Show an unwavering devotion to client’s wellness by wearing multiple hats including counselor, teacher, guide, advocate, witness, consultant, therapist, and the like.</li> </ul>

Ethical Principles	Description	Actionable Exemplars
<b>IV. Professional and Scientific Responsibilities to Society</b>	<ul style="list-style-type: none"> <li>– Creating knowledge that supports understanding and respecting people who hold membership in multiple social groups and who are impacted by context and history.</li> <li>– Professional behavior and psychological practice that promote the well-being of society and all its members.</li> </ul>	<ul style="list-style-type: none"> <li>– Support and defend human rights.</li> <li>– Avoid being a passive bystander. Be ready to speak up against human rights violations.</li> <li>– Ecological validity matters. Create knowledge and develop interventions that are not only representative of different groups but also grounded in the cultural and racialized experiences of people (see <a href="#">Chapter 20</a>).</li> </ul>

Failing to protect human rights and ethics has dire consequences. Pope (2019, p. 190) provides six key principles to help safeguard human rights and professional ethics including:

1. The map is not the territory—prohibitions, policies, and public statements can mislead us if they are not matched by the behavior of individuals and the organization.
2. The power, authority, and demands of the state can never relieve us of our individual ethical responsibilities or our duty to support and defend human rights.
3. When human rights and fundamental ethics are at risk, we must always be prepared to speak up despite the costs, search actively for opposing views and disconfirming information, and avoid the role of passive bystander when whistle-blowers, critics, bearers of bad news, or others are threatened, bullied, smeared, or attacked.
4. We are more likely to think, speak, and write clearly when we avoid euphemisms, ambiguous terms, and equating “is it ethical?” with “is it effective?”

5. If we—as organizations or individuals—allow self-interest to eclipse our ethical responsibilities to other individuals, specific groups, or the general public, we weaken our ability to defend—or even to recognize and respect—human rights and ethics.
6. Searching our own attitudes and behaviors for arrogance can save us from countless blunders (as well as making life a lot easier for our friends and colleagues). If we look back at what we have written, said, and done since this crisis began and see nothing wrong—no flaws, mistakes, or “I wish I could take that back”—it is likely we have yet to completely master this principle.

Strengthening our ethical practice requires an unwavering commitment to anchoring our practice and decision-making process to human rights. To achieve this goal, we need to consider the different ways that individuals and groups are othered and oppressed. As you read through the next sections, we invite you to consider the degree to which racism, sexism, heterosexism, ableism, anti-Semitism, and other forms of oppression have been neglected as an ethical issue in psychotherapy and how best we can navigate through the challenges and opportunities that arise when we attend to issues of systemic marginalization, discrimination, and oppression in psychotherapy.

## **ADDRESSING OPPRESSION IN PSYCHOTHERAPY**

We all develop and live in a social context that ascribes different statuses to us based on physical characteristics (e.g., skin color, visible disability) and group memberships (e.g., ethnicity, gender, religion/fait, sexual orientation, immigration status). Some people belong to groups that are privileged—that is they are ascribed a high status and receive unearned advantages and resources. Individuals who belong to groups that are ascribed a lower status in society are othered, singled out, and rejected (Chavez-Dueñas et al., 2019). Othering serves as the foundation of oppression, which refers to the cultural, economic, and political subjugation and degradation of people due to their membership in a social group considered inferior by those with power in a given society (see Charlton, 1998; Collins, 2009; Corfee et al., 2020; Johnson et al., 2004; Lumsden & Harmer, 2019). Oppression is experienced across time and context, and when it

shows up in therapy it confronts us with complex challenges and questions. Consider the following:

You're a therapist working with a client you have seen for two sessions. Prior to your third session you reviewed the client's health records from their previous therapists. You read that the client has used hate speech directed at one or more groups. During the next session, you witness the client using the hate speech described in the records.

What does the scenario evoke in you? How do you envision yourself responding in the moment? How would you work with this client, if at all? What factors do you need to consider to guide your response? Does it make a difference to you what group is targeted (e.g., anti-Semitic vs. anti-Islamic vs. anti-Black vs. anti-immigrant hate speech)? What if the client tells you a joke they just heard that they think is hilarious—It involves the bombing of a synagogue, or a police officer kneeling on a Black man's neck until he's dead, or the state separating kids from their families and imprisoning them in cages. How may knowledge of history help you make sense of what is happening? How might your personal experience growing-up shape your interpretation of what is happening with this client? What if the tables were turned and you were the one who unintentionally behaved in an oppressive way in therapy? Or if the client made a statement that is hateful or offensive toward you?

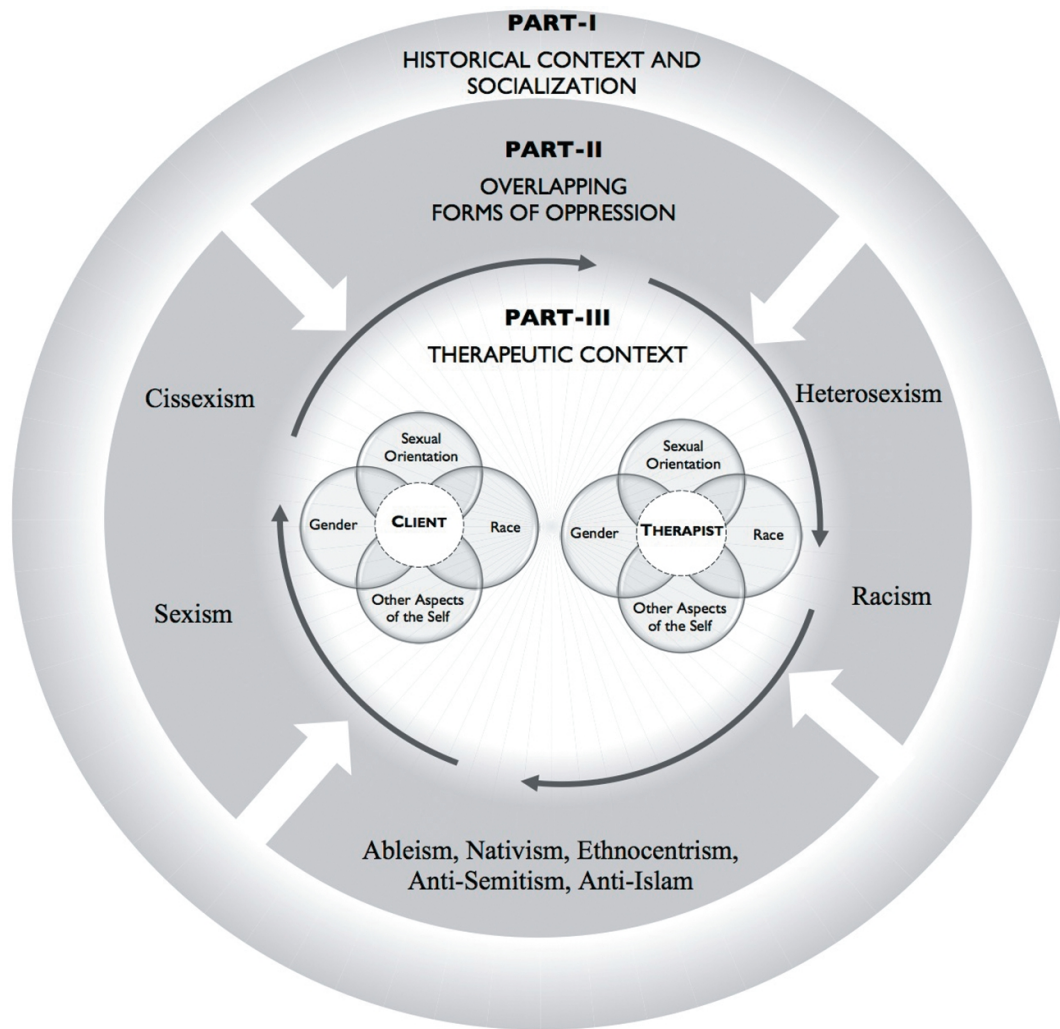
Historically, issues of systemic marginalization, discrimination, and oppression were rarely framed or addressed as ethical issues in healthcare. However, more recently there have been a growing number of scholars who address oppressions in psychological theory, research, and practice (see French et al., 2020; Leong et al., 2017; Mosley et al., 2020; Turner & Neville, 2020). Theories proposed by Johnstone and Kanitsaki (2010) help us to understand the dominant practice of not addressing oppression, prejudice, and bias in healthcare—they state

Given the significant and preventable moral harms caused by racism [and other forms of oppression] in healthcare, the question arises as to why, relative to other perplexing ethical issues in healthcare, racism [and other forms of oppression] has been poorly addressed and even ignored as an ethical issue in health service and health professional discourse? There are a number of reasons for this, including: the failure by philosophers and bioethicists to examine racism as an ethical issue and to show why it is morally wrong and hence ought to be rejected; the “illusion of non-racism in healthcare,” that is, a genuine belief among health service providers that racism is not an issue any more; a subconscious association between raising awareness of the issue of racism in health care and whistleblowing; and related to all these considerations, an overwhelming sense that the issue is just “too hard” to deal with (p. 492).

These questions and explanations lead us to more challenging questions: What do I do now? How do we proceed when addressing discrimination and oppression in psychotherapy while staying anchored in the values of justice, dignity, and respect for people who are similar and different from us?

## **THE SOCIALIZATION AND OPPRESSION IN PSYCHOTHERAPY FRAMEWORK**

Building on theories of intersectionality, socialization, and history, [Figure 23.1](#) presents the *Socialization and Oppression in Psychotherapy (SOP)* framework. The SOP framework aims to help us recognize, acknowledge, understand, and consider the possible ethical pitfalls that arise when oppression is a part of the therapeutic context. The framework consists of four parts that include: (I) *historical context*; (II) *socialization*; (III) *overlapping forms of oppression*; and (IV) *therapeutic context*.



**Figure 23.1** Socialization and Oppression in Psychotherapy (SOP) Framework.

*Source:* Pope, Vasquez, Chavez-Dueñas, & Adames (2021).

## **Part I: Historical Context and Socialization**

Fostering a society where human rights are valued and respected requires us to learn, acknowledge, and understand the long history of colonization, enslavement, segregation, dehumanization, and oppression that are part of the US and Canada and its impact on current inequities. In addition, it is important to recognize how this cultural context and history shapes our own development. In essence, and without our consent, we become a part of systems that are shaped by history which impact our experiences and access to opportunities. These systems are set in place to benefit some groups (e.g., White people, cisgender men, heterosexuals, able-bodied individuals) while systemically harming others (Black, Indigenous, People of Color, women, individuals with disabilities, sexual minorities, transgender individuals, gender non-conforming people). Throughout our childhoods we are inundated with messages about people with structural power and considered superior and those that are oppressed and treated as inferior. We pick up these messages first within our own families, who serve as the first, primary mechanism of socialization in childhood. As we grow older the educational system, the media, and society also shape and inform our perceptions of ourselves and others. Learning about and from our collective history and socialization allows us a deeper, more accurate understanding of ourselves and our clients in context. History can also help us to “contextualize and understand our present day-to-day strengths, struggles, and realities” (Chavez-Dueñas & Adames, 2020, p. 1). Helping our clients consider the role of their collective history in their lives and experience can also be therapeutic (see Adames & Chavez-Dueñas, 2017; Chavez-Dueñas & Adames, 2020).

Recognizing and incorporating the role of history in our work as therapists can be key to effective work. It allows us to step away from an a-historic view that denies, discounts, or distorts historical and contextual forces that affect therapist, client, and their shared work. Chavez-Dueñas and Adames (2020) state:

Suppressing or ignoring the role of history is unfortunately a common practice in professional programs that train people in the provision of mental health services. As a result, the practice of psychotherapy is often void of a process where the client and the therapist (a) stop to interrogate history, (b) planfully consider the role of systemic oppression on the presenting problem, and (c) incorporate the ways in which groups have survived and resisted their subjugation. Burying history, with all the richness and lessons it offers, leads to an inaccurate and negligible understanding of what may be bringing clients to therapy and how they can heal and thrive in the face of both intrapsychic distress and systemic oppression (p. 2).

Valid assessment and choice of intervention for a specific client depend on recognizing relevant context. Rosnow and Georgoudi (1986) wrote:

The idea is that psychological knowledge is made concrete and is framed by relevant factors, relations, and conditions (the setting or context) within which, or among which, human acts unfold. Contextualism underscores the idea that human activity does not develop in a social vacuum, but rather it is rigorously situated within a sociohistorical and cultural context of meanings and relationships. Like a message that makes sense only in terms of the total context in which it occurs, human actions are embedded in a context of time, space, culture, and the local tacit rules of conduct (p. 4).

Shweder (1990) boiled it down to: “The ideas of a context-free environment, a meaning-free stimulus event, and a fixed meaning are probably best kept where they belong, along with placeless space, eventless time, and squared circles on that famous and fabulous list of impossible notions” (p. 8).



## **Part II: Overlapping Forms of Oppression**

Assessing and addressing the role of oppression (e.g., racism, ethnocentrism, nativism, sexism, cissexism, heterosexism, ableism, anti-Semitism, anti-Islam) in our clients' lives not only aligns with our ethical principles (e.g., respect for people's rights and dignity) but also can strengthen the quality of care we deliver. Integrating the theory of intersectionality in therapy can help us to achieve this goal.

Intersectionality theory, first introduced by Black feminists and Women of Color social justice activists and scholars (Collins, 2009; Combahee River Collective, 1977/1995; Crenshaw, 1989, 1991), focuses on the ways in which systems of oppression interlock in unique ways to impact individuals who hold membership in multiple socially constructed groups (Collins, 2009; Crenshaw, 1989, 1991).

Recognizing intersectional issues in the therapeutic context prompts us to question whether oppression is causing, maintaining, masking, or exacerbating our clients' presenting problems (Adames et al., 2018). When we fail to consider the role of oppression in our clients' lives, we may inadvertently blame them for their own oppression or rely on interventions that don't fit the individual.

## Part III: The Therapeutic Context

The process of psychotherapy is complex. It includes the unique experiences of many worlds coming together in one space—two individuals (therapist and client), three individuals (therapist and couples), or more (therapist and family; therapist and group). Each person brings with them their individual and collective histories as well as the ways in which they are impacted due to their membership in multiple social groups based on race, ethnicity, gender, sexual orientation, religion, ability status and the like (depicted by the overlapping set of circles labeled “client” and “therapist” in [Figure 23.1](#)).

Intersectionality provides us with the language and framework to hold all of these complex, and at times conflicting, pieces together. Intersectionality can also help us deliver services that allow clients to avoid blaming themselves for their own oppression. Adames et al. (2018) state:

An intersectional stance also helps appreciate that a significant part of the distress that ethnic minority individuals [other people who are oppressed] experience is caused by systems of oppression that operate in society. For instance, an intersectional stance can assist culturally responsive psychotherapists in helping clients explore the sources of their difficulties and challenge assumptions about the same. This kind of exploration can be particularly helpful and perhaps even essential with members of oppressed communities who are often socialized to internalize and blame themselves for the challenges they face (Adames & Chavez-Dueñas, 2017; Parham et al., 1999). Thus, an intersectional stance can serve as a way to give clients permission not to self-blame for experiencing symptoms that result from living in abnormal and oppressive environments. Through this therapeutic experience, clients can begin to learn about the role of systemic oppression and its effect on their sense of self-concept and self-worth (Adames & Chavez-Dueñas, 2017). As a result, an intersectional framework can assist in depathologizing many of the struggles oppressed communities experience, and open dialogue in therapy that can assist clients in generating alternative accounts of their reality and lived experiences. Moreover, when an intersectional stance is applied, clients may begin to feel more deeply seen and understood, trust the therapist, and believe that the therapist can help them (see Wampold, 2011, 2015). These nonspecific therapeutic factors can also serve to enhance the quality of the client–therapist relationship (p. 74).

Applying an intersectional framework in therapy can help us to recognize and understand clients' problems and distress in context (see Adames et al., 2020; Chavez-Dueñas et al., 2019). We become more open, alert to, and skilled at recognizing the ways systemic and institutional oppression can influence development, stunt flourishing, foster maladaptive behaviors, cause suffering and distress, and, if unrecognized by the clinician, send both assessment and interventions off-course.

Preparing to address oppression in therapy is not only complex but also emotionally loaded. Lee (2005) describes the double bind that therapists are placed in when addressing or remaining silent about racism and other forms of oppression in therapy. He states

Why is there so much investment in preserving the silence around racism in clinical practice? While some of the explanations may be obvious, others may not be as readily apparent. I have heard White clinicians frequently express fears that they may say the wrong thing and come off sounding racist themselves. They describe the predicament of naming race in treatment and inadvertently offending a client of color (e.g., the client who says, “Why are you bringing up racism? Just because I’m Latino?”) versus not naming race—even when it is begging for attention—and then being blamed for being insensitive and unaware. As one of my colleagues expressed in frustration: It’s just not worth taking the risk. I realize that I don’t have much experience talking about racism to others outside of the therapy context and even less so within the practice context. I don’t like feeling out of control or vulnerable. So, it is easier for me just to not bring up the issue. I’d rather be accused of being unaware than be called a racist (p. 98).

An intersectional framework can also help us to pause, recognize, and consider that as therapists we too may hold membership in multiple minoritized groups. In other worlds, we can also be targets of oppression outside of and within the therapeutic context. For instance, consider a gender non-conforming therapist working with a client who makes assumptions about the therapist’s sexuality and uses homonegative and transnegative language. Or a Black cisgender women therapist working with a White cisgender gay male who uses derogatory racist language in therapy.

It is also possible that we may belong to groups with a history (perhaps stretching into the present) of oppressing others, and perhaps we ourselves have intentionally or carelessly engaged in anti-Semitism, anti-Islam, anti-Black, or other forms of oppression, or have remained passive bystanders and silent enablers as others in our group engaged in oppression.

## **Navigating Oppressive Encounters in Therapy**

Witnessing a client making a racist, sexist, heterosexist, transnegative, ableist, anti-Semitic, anti-Islamic, nativist, or any other dehumanizing comments in the therapeutic context can elicit many emotions. If the comment targets a group you belong to, you may feel helpless and oppressed similar to other times when you encounter similar hateful

comments and psychological injuries (e.g., race-based stress, minority-stress) outside of the therapeutic process. The reactions evoked by the encounter may make it difficult to decide how best to proceed. During these challenging therapeutic encounters, it is important to stay anchored to an implicit goal of psychotherapy—that is to create a relationship in which difficult things can be recognized and named when they happen. However, to do this work we need to develop both our own capacity as well as the client’s capacity to address the difficult realities of bias, prejudice, and oppression between us and within us. Below we provide five actions that may be helpful in improving our skill at addressing and naming oppression in therapy and putting that skill to use in service of the client and the therapeutic process.

## **1. Pause and Pay Attention to Your Emotional Reactions**

- Be mindful of your emotional reactions, automatic thoughts, and the social expectations that may blur how you respond in the moment.
- Recognize that deciding what to do is both an emotional task, and a professional ethical decision—thus, avoid making a hasty decision.

## **2. Contextualize the Exchange**

- Assess the client’s current mental status (e.g., disturbance in thinking or perception, delirium, neurocognitive issues).
- Consider the emotional state of the client: if they are extremely angry, aggrieved, or upset, it may be too difficult for them to deal therapeutically with their oppressive behaviors until they have cooled off a bit. However, for some clients, extreme emotional states are prime opportunities to address their oppressive behaviors in a more immediate way.
- Consider the personal and social dynamics that are being re-enacted by both you and the client (my stuff, their stuff, our stuff).
- Allow the client’s social history, presenting problems, and treatment goals to guide how best to navigate the encounter.

### 3. Decide How Best to Proceed

- Consider the nature and strength of the therapeutic relationship in your decision-making process.
- Weigh both addressing or not addressing the encounter—both options have consequences, such as:
  - Deciding to not address the encounter may communicate agreeing or colluding with the client or supporting the oppressive ideologies.
  - Addressing the encounter may be perceived as invalidating or judgmental, which may engender feelings of guilt, shame, confusion, embarrassment, and the like.
  - Addressing the encounter may also facilitate the client’s social consciousness and motivation to be curious about their own socialization and how it influences relationships.
- Invite curiosity about personal and social dynamics that are being re-enacted in therapy. Again, consider the notion of “my stuff, their stuff, our stuff.”
- Consider the timing—it may be that a more opportune time may be available in the future, especially depending on the nature of the therapeutic relationship, the content occurring in the moment, and the like.

### 4. Take Care of Your Wellness

- Pay attention to how the encounter makes you feel and impacts your sense of well-being and functioning.
- Allow yourself to take a wellness break to do things that are fulfilling and reduce your stress.
- Connect with or create a social support system that can help you process your emotions, reactions, validate your experiences, and affirm your humanity.
- Process the encounter in your own therapy or consider seeking therapy, which is a form of self-care for therapists.
- See [Chapter 17](#) on creating and using strategies for self-care.

## 5. Consider Consultation

- Connect with a trusted colleague who can help you:
  - Think through the encounter, identify things you may not be considering about the encounter, or provide ways to navigate the situation.
  - Process the emotions and reactions you experienced about the decision you made—if you had the opportunity for a redo what would you do differently?

### Therapists Can Also Perpetrate Oppression

Therapists are not exempt from being unintentionally oppressive in the therapeutic context. We can do this in various ways including: (a) using offensive language in therapy; (b) invalidating or minimizing clients' experiences and narratives of oppression; (c) silencing or ignoring the clients' attempts to share the experiences of oppression and its impact in their lives; and (d) taking too much space in therapy and centering ourselves when the client discusses experiences of oppression and dehumanization (Lee, 2005; see also Ali et al., 2005). Consider the following testimony from a therapist who states

I realize that when I hear about clients' painful experiences with racism, I quickly want to ease their pain and make it all right again. I also wish to alleviate my own anxiety and distress about racism and to preserve my efficacy as a good therapist and person. This is almost impossible. There are no easy answers to the racial problems experienced by our clients. Ironically, what most clients need is a container of safety and space to tell their truth and have it validated as just that. The "answer" may not be what is most important (Lee, 2005, p. 111).

### ENGAGING IN SOCIAL JUSTICE ACTIONS

Moving beyond recognizing and naming human rights in our professional ethics requires a commitment to actions guided by a social justice ethos. In 1967, Dr. Martin Luther King, Jr. delivered a Distinguished Address to the Society for the Psychological Study of Social Issues at the American Psychological Association Convention.

He discussed the failure of social scientists to contribute significantly to the Civil Rights Movement. He urged social scientists and practitioners to speak up about social injustices and not habituate to inhumanity. Dr. King states

I am sure that we will recognize that there are some things in our society, some things in our world, to which we should never be adjusted. There are some things concerning which we must always be maladjusted if we are to be people of good will. We must never adjust ourselves to racial discrimination and racial segregation. We must never adjust ourselves to religious bigotry. We must never adjust ourselves to economic conditions that take necessities from the many to give luxuries to the few. We must never adjust ourselves to the madness of militarism, and the self-defeating effects of physical violence (1968, p. 185).

Psychologists of Color have extensively written about the importance of centering social justice in our work. At the 1968 APA convention, Dr. Joseph L. White, considered the father of Black Psychology, called on the field of psychology to acknowledge the way it had harmed Black people and other People of Color and commit to do better (Cokley et al., 2019; see also Cokley & Garba, 2018). Dr. White asked the board and APA to

see African-Americans on their own terms and through a lens of resilience. While the board members initially balked—some even accused Dr. White of racism—his ideas gained a foothold in the field, setting the stage for the multicultural practice and research of today (DeAngelis, 2016, para. 2).

Dr. White envisioned and described a mental health profession where Black Americans would be viewed from a strengths-based approach—one where the lived experiences of Black, Indigenous, People of Color, and other historically minoritized groups would be a central component of psychotherapy. He described four principles of Black Psychology that can assist us all in engaging and committing to social justice in our work with all people including:

- Creating and maintaining a psychology that represents the voices of the people whose lives it seeks to improve. In other words, a psychology that embraces people who are diverse in terms of race,



ethnicity, gender, ability, sexual orientation, religion and the like—and that are represented in theory, research, practice, and policy.

- Producing psychological knowledge that is accessible to laypersons. He discussed the importance and power of using clear language that is free of professional jargon, which in turn can increase understanding and usage of the knowledge produced by scholars and therapists.
- Make psychological knowledge available to the public (e.g., publish open-access content in magazines, blogs, social media, professional websites, instead of solely in professional journals).
- Using a strengths-based lens rather than a deficit- based perspective to make sense of clients and communities.

Guthrie's classic 1976 book, *Even the Rat Was White: A Historical View of Psychology* (2004), carefully documents how psychology was slow to recognize these varied forms of diversity and their scientific, clinical, and ethical significance. More recently, scholars and practitioners have written about the core ethical principle of “justice” in psychology (see Leong et al., 2017; Walsh, 2015). To illustrate, Hailes et al. (2020) provide seven guidelines for integrating social justice in ethics which align well with the four principles of Black Psychology and the *Socialization and Oppression in Psychotherapy (SOP) Framework* presented earlier in this chapter. The Guidelines include:

(a) reflecting critically on relational power dynamics; (b) mitigating relational power dynamics; (c) focusing on empowerment and strengths-based approaches; (d) focusing energy and resources on the priorities of marginalized communities; (e) contributing time, funding, and effort to preventive work; (f) engaging with social systems; and (g) raising awareness about system impacts on individual and community well-being (Hailes et al., 2020, p. 1).

In the words of civil rights leader John R. Lewis, “if you see something that is not right, not fair, not just, you have a moral obligation to do something about it” (Lewis, 2020, para. 5). We believe that as therapists the ethical duty to address injustice and protect human rights extends to our professional lives and our clinical work.

## SCENARIOS FOR DISCUSSION

You work as a counselor in an elementary school where you provide services to racially and ethnically diverse children and adolescents. Your client Sarah, a 7 year-old girl who was born in Syria and was adopted at 6 by Mr. and Mrs. Harris, was referred to you for concerns related to her “inability to connect with others.” During the clinical interview, the adopted parents report how Sarah does not like to be touched by them. They described Sarah not showing any affection toward them or wanting hugs. They add that Sarah has little to no interest in social interactions, has made no friends since she began school, and even in their neighborhood she is not well liked by the other children in the neighborhood. Mrs. Harris notes that she has heard the neighbors say that Sarah is “a weirdo.” She also reported how Sarah rarely smiles or shows any positive emotions. She recounts how Sarah often runs into her room, and hides under her bed when people come visit their home. The Harris’s don’t know what to do with Sarah. Ms. Harris states, “We have given this girl everything, a place to live, food, toys, an education, but nothing makes her happy. She is so ungrateful for all that we are doing for her. We saved her life by bringing her to the United States. My husband keeps reminding me how we should have adopted an American child. I am beginning to agree with him. Maybe Sarah needs to be with her own kind, right?”

- What reactions do you have to Mr. and Mrs. Harris’ statements about Sarah?
- Would your reactions change if Sarah is a member of your own ethnic group?
- To what extent do you believe that your education and training have prepared you to deal with this situation?
- How would you respond to Mrs. Harris’ question and statements?
- What objectives or priorities would shape your response?
- How if at all would your feelings be affected by the adopted parents’ race or sexual orientation?

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Your client, who works in the medical field, shows up to a session visibly upset. You listen attentively as he describes living a nightmare. Your client proceeds to share that over the weekend a friend made a post on social media about same gender-loving marriage. Without thinking much about it, your client describes responding to the post with remarks that align with his upbringing and religious faith which defines marriage as the union between a man and a woman. Reportedly, the friend became upset about your client's remarks and proceeded to share your client's post with all of his followers. Overnight, the post went viral. People started calling your client's place of employment asking for him to be fired. Your client who is now wailing states, "This is just too much, I'm so stressed. I just want to go to sleep for good and never wake up from this never-ending nightmare. I don't know what to do—I can't lose my job."

- What are your immediate emotional reactions as you listen to your client's story?
- What are some thoughts you are having about what your client is describing?
- How may you respond to your client?
- What are some things you need to consider in this case?
- What course of action do you consider?
- Which of the two sides of the story (the friend's or the client's) do you feel more connected to? Why? How may this impact how you decide to proceed?

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During the second session of therapy following the initial intake, a White European American therapist opens the session by inviting the client to share what brought her to therapy. The client shares being overwhelmed with her work environment and the demands with being a junior adjunct instructor at a local college. She says, "my good friend believes a lot in therapy and recommended I speak with someone about my stress level." Her tone of voice fluctuated as she narrated her struggles with work. She discussed feeling that

students do not respect her and often complain about her being intimidating, distant, and cold. She says, “I feel so frustrated. I give my all to my job and these students. I know they treat me this way because I am a Black woman.” The therapist responds, “I am sure there might be other reasons why students are making those statements. Let’s think of other reasons why they may not like you?” The client then proceeds to share that a couple of weeks ago she found a derogatory term written across the wall outside her apartment. She called the police, but they told her not to worry as it had probably been “some young people who have nothing better to do.” The client recounts how upsetting and scary this had been for her given all the recent racial turmoil in the country. The therapist replies, “Gosh, I hear you ... nowadays college students are terrible, let me tell you about a similar experience I had.”

- What are your initial reactions to this case scenario?
- How are you making sense of what may be happening in this therapeutic encounter?
- What are your thoughts about the way the therapist responded to the client?
- What may have motivated the therapist to respond the way they did?
- How if at all would your feelings be affected by the therapist’s gender?
- What do you think the client needs from the therapist in this case?
- How do you think the client may be feeling after this session?
- What message is being conveyed to the client by the way the therapist responded?
- In what ways could the therapist respond to help the client not internalize the way she is being treated by her students?

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You have been working with a new cisgender male client who has been court mandated to seek services due to anger management and intimate partner violence (IPV). Treatment involves helping

the client understand: (a) the role of power and control in IPV as including physical abuse, intimidation, emotional abuse, property damage, threats, and sexual abuse; (b) the impact of rigid stereotypic gender role ideologies on self and other; (c) taking responsibility for one's own behaviors; and (d) processing the difference between anger and violence. In session, the client often challenges you. For instance, he makes statements such as "my wife asked for it, she doesn't listen to me; don't come to me talking about this feminist crap; you know women cannot live without men and they like it when we show them who's the boss; you're just as evil and manipulative as my wife."

1. What emotional reactions does this scenario evoke in you?
2. Would you share any of your feelings or concerns with the client during this session? If so, what do you say?
3. How do you think the therapist's gender may impact the therapeutic process in this case?
4. Would you respond any differently if the client was in a heterosexual versus a same gender loving relationship?

# **Chapter 24**

## **THERAPISTS IN A VIRTUAL WORLD**

### **Teletherapy, Electronic Records, and Social Media**

The novel Coronavirus pandemic (COVID-19) in early 2020 quickly shifted most clinician–client meetings into the virtual realm; however, the move from face-to-face to videoconferencing services was underway long before the pandemic hit. To illustrate, as early as the 1950s, clinicians at the University of Nebraska set up an interactive audiovisual line to connect patients, healthcare providers, and medical students for neurological examinations.

By the early twenty-first century, digital technology was transforming how healthcare information and services were provided. Hawn (2009) wrote in *Take Two Aspirin and Tweet Me in the Morning: How Twitter, Facebook, and Other Social Media Are Reshaping Health Care*: “across the health-care industry, from large hospital networks to patient support groups, new media tools like weblogs, instant messaging platforms, video chat, and social networks are reengineering the way doctors and patients interact” (p. 361; see also Fischer & Soyez, 2015).

### **EMPIRICAL SUPPORT AND VARIED VALIDITY**

In the decade before the appearance of COVID-19, considerable empirical evidence supported the use of teletherapy (e.g., Bashshur et al., 2016; Hubley et al., 2016; Shigekawa et al., 2018). Focusing on group therapy, Gentry et al. (2019) reviewed 40 studies and found that “video teleconference groups are feasible and produce outcomes

similar to in-person treatment, with high participant satisfaction despite technical challenges” (p. 327).

However, studies showed variability in the validity of psychological assessment (including neuropsychological and forensic assessment). A meta-analysis of 12 studies of neuropsychological test administration by videoconference, for example, found both untimed tests and tests that allowed repetition produced scores that were at least one-tenth of a standard deviation lower than scores from tests administered face-to-face (Brearly et al., 2017). Videoconference administration of verbally-mediated tasks (e.g., digit span, list learning, and verbal fluency) did not affect scores, but scores for the Boston Naming Test (BNT), when administered by videoconference, were one-tenth of a standard deviation below those for in-person administration. DeYoung and Shenal (2019) found that “administration of the Montreal Cognitive Assessment using telehealth technology did not significantly alter the total scores” (p. 197).

## **BENEFITS OF DIGITAL CLINICAL WORK**

The pre-COVID-19 digital shift offered significant advantages, particularly in saving time. Dorsey and Topol (2016) noted:

Numerous organizations, from academic health centers to startups, now offer low-cost virtual visits (less than \$50 per visit) around the clock for the “most common, most irritating, most inconvenient” conditions...By contrast, it takes an average of 20 days to secure a 20-minute appointment with a physician that with travel and wait time consumes two hours (p. 154).

Consider also the benefits, again from the pre-COVID-19 world, illustrated in the following four vignettes:

Roberto lives in a small Florida town and uses a wheelchair to get around. He does not own a car. Feeling lonely and trapped in a job he hates; he is ready to begin therapy again. Ten years ago, a cognitive behavioral therapist had helped him after he had been in a serious car wreck. Wanting to work with a cognitive behavior therapist again, he discovers that the closest CBT office is over 2 hours away. The distance is impractical. He could not take that much time off work even if he could find someone to drive him there and back once or twice a week. Instead, he decides to search the Web, examining professional sites, consulting referral databases, and following leads. Within days he has found Dr. Spillane, a psychologist specializing in CBT who will provide therapy online. During a 45-minute session each week, they each sit at their computers, using Webcams and their computers' audio systems to communicate with each other.

■ ■ ■



Dr. Mosley's third patient of the day is Edgar, a young man with an impulse control disorder and a history of violence and alcohol abuse. It is Edgar's sixth session and he seems starkly different. He is flushed, agitated, and clearly not sober. He begins speaking loudly and is soon screaming. His company downsized and fired him four days ago. The bank won't give him a loan he needs to tide him over. It seems everyone is against him. This morning he found evidence that his best friend, a man he had often mentioned in therapy—their families shared a vacation each year and often went on weekend hiking and camping trips together—had been sleeping with Edgar's wife. Edgar got up and began pacing as he talked about how a man just could not put up with something like this, that he would put a stop to it and make his friend pay. He seemed to get more and more worked up. He stopped pacing and turned to face Dr. Mosely and said "I'm going to get a gun and kill him and all his family right now." Edgar was out the door before Dr. Mosely had any chance of stopping him. She ran to her phone, called 911, and told the police her patient's name, intentions, and home address, though he had been clear that he was going straight to a gun shop and then to murder his friend and the friend's family. She did not know the name of the friend. She then called Edgar's home phone, hoping someone there would be able to identify the friend, but there was no answer. She sat down at her computer and Googled her patient's full name. She found Edgar's Facebook page and by chance it was not private. She was able to view vacation photos and the name of Edgar's friend. She used that name to find the friend's phone number, which she gave to the police, who were able to contact the family and protect them until they found Edgar and placed him on a 72-hour hold in a locked facility for a psychological evaluation.

■ ■ ■

Dr. Christie is the only therapist in a very remote rural setting. A man who just moved there from Rwanda contacts him because his 13 year-old daughter is distraught and depressed. She refuses to tell her family why she is upset but tells her father that she needs to see a therapist. The problem is that although the father can speak a little English, his daughter speaks only Swahili. The daughter will say nothing to the therapist if her father is to serve as translator. No one else in the area speaks both Swahili and English. Dr. Christie begins searching the Web and soon finds someone fluent in both Swahili and English who has been trained to serve as a translator in mental health settings. She is aware of the sensitive issues and intense emotional reactions that can arise, the need for rapport and precise translation, potential problems due to cultural differences and regional dialect, and confidentiality requirements. During each of Dr. Christie's sessions with the daughter, the translator will join them in videoconference.

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Jean is a born-again Christian who tries to live her life in accordance with the Bible. Profoundly depressed, she talks with her pastor, who prays with her, provides spiritual guidance, and suggests that meeting with a therapist might be helpful. There are three therapists in her town. She schedules an initial session with each but never feels comfortable talking with them and does not feel that they understand, appreciate, or perhaps even respect her beliefs. She asks her pastor for help in finding a therapist who shares her religious beliefs. Her pastor asks the church hierarchy and his fellow pastors for help, and a week later he provides Jean with the name of a therapist, Dr. Salter, who is a member of another church in the same denomination who will meet with her weekly via videophone. Though Jean does not have a videophone and does not even own a computer, the pastor will let her use the church's videophone and computer in one of the church offices once a week.

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These vignettes illustrate just a few of the many benefits that digital technologies provide to us and our patients, including the many ways

they make distance and barriers to needed mental health services disappear.

## **RISKS, DOWNSIDES, AND DISASTERS**

The benefits of using digital technologies as a form of service delivery come with downsides, risks, and occasional disasters. For example, Ramsetty and Adams (2020) commented that “Telehealth has been lauded as a means to close the healthcare gap to rural populations...; however, recent authors have raised the concern that technology may actually be widening the gap between groups both nationally and even globally due to persistent social, economic, and political factors” (p. 1147). A significant part of this gap is access to broadband internet access, which is necessary for effective videoconferencing. The Federal Communications Commission (FCC) *2018 Broadband Deployment Report* emphasized that “Rural and Tribal areas continue to lag behind urban areas in mobile broadband deployment” (Federal Communications Commission, 2018, para. 8), finding that almost one out of every three households in rural and Tribal areas lack broadband.

Unfortunately, the transition to the digital world also presents a massively increased threat to privacy. Digital technologies take confidential information that was once confined to paper charts, kept under lock and key, and spread it over electronic networks. Carelessness, human error, and hacker ingenuity make networks vulnerable to a growing cascade of breaches. The miracles of the internet, that allow therapists and clients who are in different states, provinces, or countries to meet electronically, enables hackers who may be half a world away to access a therapist’s electronic records, copy them, and then alter, destroy, publicize, or hold them for ransom.

Wike noted that by 2014 the private health information of around one in ten people in the United States (U.S.) had been breached. Liu et al. (2015) reported that 29 million records containing confidential patient information had already been breached between 2010 and 2013. Over the next four years 154,415,257 patient records were breached (Ronquillo et al., 2018). Additionally, a study of breaches involving 164 million patients found that more breaches involved

laptops and other mobile devices (46%) than involved network servers (29%). Jiang and Bai (2019), who conducted that study, noted that most of the breaches “were not from external causes but were attributable to internal mistakes or neglect” (p. 267; see also Hossain & Hong, 2019).

Policies such as the *Health Insurance Portability and Accountability Act* (Health Insurance Portability and Accountability Act of 1996 [HIPAA]. Pub. L. No. 104-191, 110 Stat. 1936, 1996) and the *Health Information Technology for Economic and Clinical Health* (Health Information Technology for Economic and Clinical Health [HITECH] Act, 2009) were enacted to promote practices preventing privacy breaches. However, these policies promising privacy often failed to deliver in practice. Freeny (2007) wrote: “The HIPAA (Health Insurance Portability and Accountability Act) privacy rules suggested that the bar would be raised for clinical privacy, but, in fact, the standards were significantly lowered” (p. 13; see also Alonso-Zaldivar, 2008; Richards, 2009).

Sometimes those policing privacy fail to follow the rules they enforce on others. In 2014, the *Canadian Broadcasting Corporation* reported that the *Office of the Privacy Commissioner of Canada* had lost an unencrypted hard drive with private data on hundreds of people (Chung, 2014). The report noted that “The information on the hard drive dates back 12 years, even though a government-wide policy says records of this kind aren’t supposed to be kept for more than seven” (Chung, 2014).

In other instances, patient information is sometimes kept in databases without informed consent. Those who maintain the databases may react strongly against those who object. *The British Medical Journal* reported that a “junior doctor...was excluded from work for five years after she objected to the inclusion of patients’ medical records, including her own, on research databases without consent” (Dyer, 2008, para. 1).

As we house confidential patient information in distant servers, send it through many networks, and carry it around in our laptops and personal digital assistants, it becomes ever more vulnerable to theft and other forms of loss. Here are just a few examples:

- A ransomware attack on Magellan affected 365,000 patients (Davis, 2020).
- “Clinical Pathology Laboratories, based in Austin, Texas, says 2.2 million patients may have had their names, addresses, phone numbers, dates of birth, dates of service, balance information and treatment provider information impacted by a security breach” (Landi, 2019, para. 2).
- The *Toronto Globe & Mail* reported that “Alberta Health Minister Fred Horne said Wednesday he is ‘outraged’ a laptop containing key information on 620,000 patients was stolen four months ago but only now brought to his department’s attention. The information includes unencrypted names, birthdates, health card numbers, billing codes, billing amounts and diagnostic codes for patients” (D. Bennett, 2014, paras. 2–3).
- Reuters reported that “a data security breach of Montana’s state health records has compromised the Social Security numbers and other personal information of some 1.3 million people, but the full extent of damage from the intrusion is unclear” (Zuckerman, 2014, para. 1).
- The *Canadian Broadcasting Corporation* released an article stating: “This latest breach of privacy is the fifth, to come to light at Eastern Health since 2012. In July 2012, Eastern Health dealt with the largest privacy breach in the province’s history.... [Beverley Clarke, vice-president of privacy for Eastern Health] indicated that some in the workforce don’t get how significant the issue is. ‘All 13,000 employees, I guess, truly do not understand yet that in fact this is inappropriate,’ Clarke said” (“Insider tipped Eastern Health to latest privacy breach,” 2014).
- The *Wall Street Journal* reported that “Anthem Inc., the country’s second-biggest health insurer, said hackers broke into a database containing personal information for about 80 million of its customers and employees” (Matthews & Yadron, 2015, para. 1).
- According to the *Canadian Broadcasting Corporation*, “The personal-health data of millions of British Columbians has been

accessed without proper authorization...” (“B.C. privacy breach shows millions affected,” 2013, para. 1).

- *Federal News Radio* reported that “Veterans Affairs sustained another data breach, putting more than 7,000 veterans at risk of identity theft” (J. Miller, 2014, para. 1).
- Community Health Systems, according to the *Wall Street Journal*, announced that “its computer network was a target of an external criminal cyberattack...that affected data related to some 4.5 million individuals” (McCarthy, 2014).

In addition to the increased potential for breaches to clients’ confidential information, teletherapy raises additional privacy concerns. For instance, the use of videoconferencing often assumes that both parties (therapist and client) can speak freely without others listening to their conversations. However, this may not always be the case. For example, are you using a device that has end-to-end-encryption? Do you and your client have a private space in your respective locations that is free of distractions, unexpected interruptions, or eavesdropping?

Is your client uncomfortable sharing their physical living conditions with you?

## **SOCIAL MEDIA CHALLENGES**

Technology presents other potential problems in the form of social media. Clinicians encounter an array of challenges in this area. First, we face the challenge of managing the boundaries of information about ourselves that appears on the internet. This information appears in our Twitter, Facebook, and Instagram (IG) accounts, blogs, op-eds, websites, and a diversity of other form of online presence. Some of what we post, tweet, or otherwise share—vacation photos, scenes from our dating life, political rants, jokes, and so on—we may think of as personal, but if it is public, it may become part of our professional identity and end up complicating both our relationships with clients and the therapy itself. In many ways, our digital footprint is like permanent ink. It may also complicate the evaluation process when we apply for internships or employment. It

is important to realize that many clients are understandably curious about the personal life of their therapist and will find it exciting and enlightening to search the internet for anything and everything they can find. Some clients may more actively exploit social media to breach the therapist's privacy (see Kolmes & Taube, 2016). In her study of social media and their impact on therapeutic relationships, Kaluzeviciute (2020) reported: "Direct breaches in therapist privacy were found to be more frequent with non-psychoanalytic psychotherapists due to therapists' higher online presence" (p. 303).

Second, we face the challenge of managing the boundaries of information about our clients. We may want to talk about our work in a tweet, blog post, IG, or Facebook page, and the informality of social media can blur our ethical responsibility to maintain client confidentiality. Therapists who thought they had sufficiently disguised the identity of a client have found out they were wrong. Clinicians who thought they were operating within a securely private area have found that the privacy settings were not correctly adjusted. A study of residents' Facebook pages containing unprofessional content found that HIPAA violations were among the most common form of unprofessional content (Langenfeld et al., 2014).

Third, we face the challenge of resisting the temptation to masquerade as someone else. Authors have been known to create fake identities to praise their own books. Researchers have been known to create fake identities to peer review their own studies. One of the most fascinating accounts of a clinician undone through his use of technology involved an Ivy League-educated physician on trial for malpractice. During cross-examination, he was suddenly asked if he was "Flea." As the *Boston Globe* (Saltzman, 2007) reported:

Flea, jurors in the case didn't know, was the screen name for a blogger who had written often and at length about a trial remarkably similar to the one that was going on in the courtroom that day. In his blog, Flea had ridiculed the plaintiff's case and the plaintiff's lawyer. He had revealed the defense strategy. He had accused members of the jury of dozing. With the jury looking on in puzzlement, Lindeman admitted that he was, in fact, Flea. The next morning, on May 15, he agreed to pay what members of Boston's tight-knit legal community describe as a substantial settlement—case closed.

## Social Media Attacks<sup>1</sup>

Maintaining an online presence, even when doing so carefully and while being mindful of our professional roles, can lead to cyberbullying (social media attacks). Social media attacks can terrify and paralyze us. Aggressors aim to silence, shame, humiliate, bully, intimidate, threaten, terrorize, and virtually destroy their human target. They wield weapons like rumors, innuendo, lies, hate speech, and violent imagery. A Pew Research Center Survey (Duggan, 2017) found 41% of adults in the United States report having been harassed online, and 62% consider it a major problem. Below we provide some steps you may find helpful if you're targeted in a social media attack.

- **Don't worry alone.** Social media aggressors want to single you out, isolate you, and cut you off from allies. Don't let them. Reach out to people you trust – those who will listen, validate, respect, and support you.
- **Don't fan the flames.** Digital lynch mobs want to feel their power and see you jump. Whatever you say will reward them and feed the attack. They did not target you because they wanted to reason with, understand, or respect you. Their goal is to shame, condemn, and terrorize you. They want you to live in fear and silence your voice. Refuse to engage or even acknowledge them.
- **Create a safety plan.** If social media attacks threaten your safety or privacy, ask people you trust to monitor any threats you



might have missed, and work with them to develop a plan to keep yourself safe. A safety plan can include:

- removing personal information (e.g., addresses, phone numbers, email addresses) from public sites
- making your social media profiles private
- blocking aggressors
- becoming aware of your surroundings
- making sure you are accompanied in public
- Trying to put yourself in the shoes of an attacker: What areas of vulnerability do you see? A good plan will address those vulnerabilities.

- **Ask for support from organizations.** Digital lynch mobs can try to get you fired from your job, expelled by your college or university, or thrown out of other organizations. Explain to those in your university or other organization what is happening, ask for their help, and find out what specific steps they are willing to take to support you.
- **Take care of your body, mind, and spirit.** Social media attacks can make it hard to sleep, eat, think clearly, relax, or “be yourself.” Find ways to take care of your health. Sometimes just talking about it with a special friend or group of friends will help. Some people find help in prayer, meditation, and other spiritual traditions. Others talk with psychologists, psychotherapists, counselors, or other mental health professionals. If you like animals, spending time with pets can be healing. If your housing doesn’t allow pets, consider visiting a dog or cat at a shelter—often these vulnerable creatures are lonely and scared, and spending a little time with them may make you both feel better.
- **Document, document, document.** Keep documents that provide evidence of the digital aggression. Take screenshots of content in the event the situation escalates—perpetrators may later delete their attacks. Evidence of harassment or threats can be crucial when explaining the situation to your university or other employer, contacting the police or other law enforcement agencies, filing a civil lawsuit, or lodging another type of formal

complaint. Make a backup copy of your documents and store it in a safe place. Consider giving a copy to a trusted friend, professor, or co-worker.

- **Speak up for others.** Social media bullies count on our shared human tendencies to stay back, avoid trouble, and not get involved. If we allow ourselves to do nothing when someone is under attack, we become passive enablers. Ask the targeted person, how you can help. We are stronger when we are together. Just listening supportively to someone who is under attack may be a first step in helping turn the situation around. You can also express your public support for the person being targeted or threatened. In cases where the digital lynch mobs are trying to jeopardize a person's employment, allies have collectively responded by creating petitions and writing letters in support of the person being targeted.

## TEST SECURITY IN THE DIGITAL WORLD

The use of digital technologies provides us with all sorts of possibilities, including the opportunity to make information about psychological tests—along with the test items themselves and scoring guides—widely available to anyone who can access the internet. Unfortunately, not all websites are secure. For instance, Schultz and Loving (2012; see also Hartmann & Hartmann, 2014; Schultz & Brabender, 2013) found that of the top 88 websites offering information about the Rorschach, 19% posed a direct threat to test security. In addition, testing protocols and images may be reproduced online to the public, which can lead to additional problems. A controversial instance involved the popular website Wikipedia. Cohen (2009) reported that “the online encyclopedia Wikipedia has been engulfed in a furious debate involving psychologists who are angry that the 10 original Rorschach plates are reproduced online, along with common responses for each” (para. 3). LoBello and Zachar (2007) found that

Psychological test materials are available on eBay. Overall, about half of the test items listed for sale did not specify any restrictions on purchases. The sale of test manuals containing the administration procedures and responses to items represents the greatest potential breach of test security. However, even when test manuals were offered for sale, almost 40% of these items were listed without purchase restrictions (p. 69).

The tests they found for sale on the internet included the *Wechsler Adult Intelligence Scale—Revised*, *Wechsler-Bellevue Intelligence Scale*, *Wechsler Individual Achievement Test*, *Wechsler Preschool and Primary Scale of Intelligence—Revised*, *Wechsler Memory Scale—Revised*, *Rorschach*, *Thematic Apperception Test*, *Minnesota Multiphasic Personality Inventory*, *Minnesota Multiphasic Personality Inventory—Adolescent*, and *Behavior Assessment System for Children—Second Edition*. For examples involving other tests, see Bauer and McCaffrey (2006).

## **FIVE SPECIAL PITFALLS**

The topics reviewed in this chapter shine a light on areas within digital and social media that require special awareness. The vignettes below illustrate five of the most common pitfalls clinicians encounter in the digital world.

### **Pitfall 1**

Skeptical at first about trying to conduct therapy sessions over the internet—he used his simple computer only for e-mail. However, the COVID-19 pandemic forced Dr. Chandler to begin using Zoom to meet with his clients. Not trusting his limited computer skills, he hired his neighbor's daughter, a Massachusetts Institute of Technology graduate student home because it was a period of lockdown early in the pandemic, to select a comprehensive system, install it for him, and teach him how to use it. She spent the first week buying and installing the components. She spent the second week teaching him the system's wonders: How to use the Webcam to talk with another person, how to record the sessions, how to keep his patients' information and treatment files in digital form, how to use

the system's scheduling software, and how to back up all his data using an independent hard drive.

When Dr. Chandler felt confident he knew how to operate the comprehensive system she'd created, she installed a program on his website allowing people to request appointments and pay in advance using credit cards or PayPal.

One of his new clients was Philip, a fragile, shy, anxious ballet dancer. Phillip felt that no one really listened to him but was also afraid to talk honestly with others about himself. He would refer indirectly to his "secrets," suggesting that if anyone knew what he was really like, they'd hate him and never speak to him again. It took Philip months to work up the courage and trust to tell Dr. Chandler what he had never told another soul. He had barely gotten his secret out before he began sobbing, unable to continue. It was at this moment that Dr. Chandler's system crashed.

It was only later that afternoon, after he'd finally been able to find his neighbor's daughter for an emergency visit, that he learned that the data kept on his computer was gone. A new computer worm had systematically erased and repeatedly overwritten his schedule, his billing records, his patient contact information and files, and his recorded sessions.

This, however, was not the worst of it. The worst of it was when the computer specialist pointed out that because he'd left the independent hard drive on which he made his backups plugged into the main system "for convenience," the worm had been able to access it, erase it, and overwrite the disk repeatedly, making any attempt to rescue the original data hopeless. All of his data, including his backup copies, were gone.

Dr. Chandler wanted to contact Philip right away, to tell him what had happened and to find out how he was, but because he no longer had any contact information, it was some time before he was able to track him down.

*Dr. Chandler's misadventures illustrate an important reality: It is not just therapists who are both fallible and vulnerable; so are our computers. An important part of using computers and technology in a therapy practice is evaluating carefully when and how they can*

*fail and preparing for those failures and for the worse case scenarios.*

## **Pitfall 2**

Dr. Doyle was tired of it all. In solo practice, she sat in the same chair in the same room most of the day, getting very little exercise. She was exhausted by the end of the day and didn't feel like doing much of anything except going home, eating dinner, and going to bed.

On impulse, she signed up for a noon beginner's class in belly dancing. It changed her life. She loved it. She looked forward to it every day, and every afternoon she felt energized. She knew she was becoming more fit, building stamina, and toning her muscles. But mainly belly dancing brought joy to her life.

A woman in her class told her about a belly dancing website. You could sign up and become part of a discussion list. Members shared their love of belly dancing and traded information about dances, clothing, courses, and festivals. Dr. Doyle visited the website and signed up.

It was only later that Dr. Doyle learned that by signing up, she had agreed to allow the organization to access her computer's address book. It used the names to send invitations to join the belly dancing list to everyone in her address book. The invitations mentioned her name and were written ambiguously so that recipients might assume they came from her. Her address book contained the names of her current and former therapy patients, attorneys she'd been in contact with for cases in which they'd be deposing and cross-examining her as an expert witness, a former boyfriend, various colleagues including members of the state licensing board, her rabbi, and her bank's loan officer to whom she'd applied for some funds to tide her over.

*Dr. Doyle's misfortune shows the hazards of not understanding the implications of participating in cyberactivities such as joining lists or providing information on websites. Many of us become used to reflexively clicking "agree" without reading all the dull boilerplate and legalese of policy statements when we install new software. That the reflex takes over when we journey around the Web. And*

*even if we read every statement before agreeing, we may not fully understand the ambiguous or technical legal language used, and many of them may not cover material that is crucial for us to make informed decisions and avoid disasters .*

### **Pitfall 3**

Dr. Kashmoula had been working via Zoom with a girl in her mid-teens for close to three months. Her parents who lived in a remote area, were desperate to find some way to help her, but were unable to travel on a regular basis to a therapist's office. The girl was home schooled and highly intelligent. Dr. Kashmoula was sure that one of her problems was loneliness. She spent most of her time in her room, painstakingly creating stop-action videos, which she refused to share with Dr. Kashmoula, saying only that she always put them on the Web and that he could find them if he was really interested.

Attempts to engage her in conversation, to encourage her to talk, or to ask any kind of questions were met with sullen evasions or passive-aggressive comments. It took time to gain her trust.

In the session when she finally started talking, she began telling Dr. Kashmoula how much she hated him. He was like almost everyone else in her life. He did not listen. He didn't care about her. He just wanted to control her. He said stupid things. She hated him.

It wasn't the most comfortable session for Dr. Kashmoula, but he felt very good about the breakthrough. She was expressing what was going on inside her in a very honest and direct way. The real work had begun.

It was only several days later that Dr. Kashmoula's friends and colleagues alerted him to how he was becoming an international sensation. When he typed his name into Google and followed the links, he discovered what his patient had done.

She had been recording their sessions, and had posted a clever short video, "My Experience of Therapy with Dr. Kashmoula," on YouTube and TikTok. Her video had gone viral.

The video showed segment after segment of her saying something she'd never said during the session but had recorded later for her

video. After each segment, she'd inserted a clip of something Dr. Kashmoula had said during their sessions, taken completely out of context but chosen because it made him look like a fool.

One segment showed her saying "Dr. Kashmoula, I feel like no one listens to me, no one hears what I really say," followed by a clip of something he'd said when the Zoom audio feed had been temporarily interrupted: "I can see you but I can't hear anything you're saying."

Another segment showed her saying, "My parents are only interested in my always-perfect brother, he's all they want to talk about, it's like no one is interested in me, I don't even exist." This was followed by Dr. Kashmoula saying "I wonder if we could talk about your brother." Another showed her yelling, "I can't take it anymore! I'm going to hang myself with this noose!" followed by him smiling and saying "What a wonderful idea! I was hoping you would! I think this is a good time to end our session."

Dr. Kashmoula discovered a growing number of alternate versions of his patient's video gaining popularity on the Web. Kids had downloaded the video, making TikTok copies, and replaced his actual patient with themselves as the patient, making up new lines for him to respond to, each person trying to create a funnier or more outrageous version.

Stunned and enraged at what his patient was doing to his dignity, image, and reputation, Dr. Kashmoula grabbed the phone and called the city's most powerful law firm, making an appointment that afternoon with the firm's most feared and successful litigator.

Quickly taking a seat in the litigator's office that afternoon, Dr. Kashmoula explained the decision and his intention not only to take legal action to have the videos taken down but also to sue his patient for every penny her family had.

Accustomed to listening to outraged people consumed with a molten determination to sue, the attorney listened with the patience of someone who charged \$500 an hour for consultation. She explained the difficulties of legal action against something that was clearly satire and likely protected by the First Amendment, the significant expenses—expenses that Dr. Kashmoula would have to pay out of his own pocket—involved in preparing for and conducting a trial, the

fact that filing suit would make the videos more popular than ever, the problems of dealing with the many jurisdictions—some outside the United States—from which different kids had uploaded their versions of the video, and what would happen to his reputation if the media began portraying him as someone suing parents for not stopping his child patient from making fun of him.

*Dr. Kashmoula had been unaware of how the technology he used had changed the nature of his practice, affected the privacy of what he said and did as a therapist in his own office, and given tools to his patients that could be used in ways he had not imagined.*

## **Pitfall 4**

Dr. MacDonald had worked as hard as anyone else in his graduate training program, and his transcripts were as good as anyone else's who graduated that year. He'd worked with some of the program's best professors, and they seemed to like him. He'd gotten into a good internship and done well. His supervisors had praised his skills and invited him to stay on an extra year so that he could be licensed by the time he was ready to look for a position as a clinician in the student counseling center of one of the universities.

He found entry-level openings for a counselor at 10 centers and submitted applications, making sure all the transcripts, letters of recommendation, and other materials arrived before the deadline. What surprised him was that not one of the schools called him for an initial interview.

He had a very rough year after leaving his internship setting, able to find a clinical job—but not in a university counseling center—only after 10 months of searching.

It was only after he'd been licensed for almost three years that a friend who'd been working at a university counseling center explained why he'd had such a hard time finding work.

Dr. MacDonald had become well known among psychologists on the internet, and not in a particularly good way. He posted frequently on psychology lists, pointing out mistakes in his colleagues' messages, ridiculing questions as stupid or naive, and insulting anyone who disagreed with him. He was especially hard on students and on



colleagues who did not belong to the particular list on which he was posting.

*Dr. MacDonald was unaware of how his posts, which he thought were so effective in shaping opinions about other people, actually shaped how people viewed him. He did not realize that the reputation he created in cyberspace might play a role in how future employers and members of hiring committees viewed him as a job candidate.*

## **Pitfall 5**

Dr. Akaba had a thriving Zoom therapy practice. She had set up her website so that applicants, who created a user name and password, filled out applications. When she found an appropriate candidate for therapy, the patient scheduled an appointment and paid (using a credit card or PayPal) via the website. At the scheduled time, she and the patient met via Zoom for each therapy session.

One of her most interesting patients was a young software engineer who had become independently wealthy when he sold his company to a large corporation. His problems were mainly indecision about what he now wanted to do with his life and his travel schedule (he had to fly to other countries to troubleshoot their implementation of the software products his company made—he was obligated to travel as one of the contractual stipulations to the corporation that had bought his company).

Three months into the treatment, Dr. Akaba received an unpleasant letter, sent registered mail, return receipt requested, from an attorney in a distant state. She discovered that the patient was actually a minor whose parents were involved in a bitter divorce. The lawyer, representing one of the parents, wanted to know why Dr. Akaba was providing treatment to a minor without the informed consent of the boy's parent. He also wanted to know why Dr. Akaba was providing services that required a license when a check with the licensing board showed that Dr. Akaba was not licensed to practice in the country where the boy lived and was receiving treatment. He asked Dr. Akaba to send the boy's assessment and treatment records to him within the next five business days. Soon after, Dr. Akaba learned that the boy was not a software engineer and had never

owned his own business. He was in high school and worked part-time at a fast food outlet. The boy apparently believed his fantasies and suffered from a serious psychological disorder. However, Dr. Akaba had not recognized the disorder, conducted an adequate assessment, or provided the appropriate treatment.

*Dr. Akaba's focus on the wonders of website and videoconferencing technologies led her to overlook the responsibilities they bring with them. She failed to notice that the Webcam's power to let her to work with patients in distant states and provinces meant that she needed to be familiar with and comply with the relevant laws and regulations. Working within the framework of videoconferencing seemed to distract her from doing the kind of careful assessment she no doubt would have conducted had she been working with the client in person.*

## **QUESTIONS TO ASSESS USES OF DIGITAL MEDIA**

Given the many pitfalls that can occur when using technology to provide services, it is important to carefully consider what we can do to prevent some of these difficulties from happening. Below we provide some questions and responses that we hope may be helpful in avoiding pitfalls, strengthening ethical intelligence, and meeting the challenges of working in the digital world.

### **Where Is the Computer?**

Some readers may have visited clinics and seen confidential information about patients on a computer screen. One of the first questions to ask is: When this computer is on, who can see the screen? Can anyone who is not authorized see patient names or other sensitive information on the screen? This can be a problem for those who work with confidential information on portable computers during long flights or in terminals, waiting rooms, and other public spaces.

When the computer is unattended—whether for only a few minutes or overnight—is there a secure barrier between it and anyone who

might want to access it or steal it? If you were to offer someone a considerable sum of money to access the computer without authorization or to steal it, how confident are you that you would not lose your money?

## **Is the Computer Protected from Hackers?**

If the computer is hooked up to the internet, a software or hardware firewall that includes Two-Factor Authentication can help protect against unauthorized entry and use of information stored on the computer. Key word here is “help.” No method of protection is 100% effective. All have strengths but also vulnerabilities. The more layers of protection you use, the more secure your confidential data will be. If one or two layers fail to block unauthorized entry, others may work. Like a house with many locks and forms of security, a well-protected computer may discourage all but the most determined and skilled hackers.

## **Is the Computer Protected from Malicious Code That Can Access Confidential Information?**

When computers connect to the internet, they are vulnerable. Security hardware and software can lower but not remove the vulnerability. Viruses, Trojans, worms, and other malware continue to find more devious paths to fool a computer’s defenses. E-mails formatted in HTML can mask malicious code. E-mail attachments and links can infect a computer before they are opened. A visit to a website may result in a malicious program downloading into the computer without the user’s knowledge. These programs can look for a computer’s most sensitive files (e.g., those that fit the patterns of social security numbers, credit card numbers, passwords, financial statements; those that contain words like *private*, *confidential*, *clinical*, or *medical*). They can transmit those files to a temporary throwaway address in another country, post them on an anonymous website, or send them to every e-mail address in your computer’s memory.

One approach to protecting confidential information on a computer is a two-step process: (1) keep several layers of protection on the

computer; and (2) keep the information encrypted on a removable medium (such as a portable external hard drive, secure USB flash drive, CD, or DVD). The removable medium would always be kept secure and would be hooked up to the computer only when the therapist is using it.

An approach that offers more protection is to use one computer for connecting with the internet and storing nonconfidential data and a separate computer that is never hooked up to the internet or other networks to store confidential information. Because the confidential information is stored on a completely isolated, stand-alone computer, there is no wired or wireless link from it to any network and it cannot transmit data to unauthorized recipients.

## **Is Your Computer Protected from Viruses and Other Malware?**

Do you have a good antivirus program? Do you maintain it by installing the company's new virus definitions and updates?

## **Is the Computer Protected Using a Strong Password?**

If someone finds a computer unattended or steals it, a system of passwords can make it difficult to access confidential information. Loading the operating system when turning on the computer, gaining access to a set of files, and opening a particular file can be made contingent on passwords.

Words do not make the most secure passwords. Dictionary programs are readily available to hackers, who use them to enter a password-protected computer. A password is more likely to block password-breaking software if it has a combination of lowercase letters, uppercase letters, and symbols and if it runs at least 12 characters long.

Any password is useless if someone who is determined to access your computer sees it written down somewhere. Someone sitting at your computer and attempting to gain unauthorized access is likely to look through the papers on and in your desk (including under the

keyboard and on the monitor) to see if the password has been jotted down.

## **Is Confidential Information Encrypted?**

While passwords can limit access to information by unsophisticated users (assuming you have a strong password and do not leave it written on a slip of paper by your computer), hackers can easily get around those passwords and read, steal, alter, or destroy the information. However, even if someone defeats your password protection, they will still face a formidable layer of protection if your computer's files are encrypted. Encryption scrambles or camouflages information (e.g., progress notes, billing information) by changing it into a form that makes it extremely hard for those without the encryption key to restore to readable form. Apple, Microsoft, and other makers of the major computer operating systems as well as other companies (e.g., PGP at [www.pgp.com](http://www.pgp.com)) provide software programs that will encrypt files. However, the free hard disk encryption programs that come with the Apple and Microsoft operating systems are *not* turned on by default—you have to turn on these disk encryption programs for them to start the encryption protection—and only a tiny minority of users turn them on (Goodman, 2015).

In an excellent article, psychologist Samuel Lustgarten (2015; see also Lustgarten & Elhai, 2018) gives us solid advice:

Encrypt Everything. If possible, every client record and communication should be encrypted. When mobile devices are used for client contact (i.e., text messages and/or e-mails), it is important to consider the phone's encryption capabilities. Currently, iPhones, with a good password, can be encrypted and protected from password attacks for about 5.5 years (Apple Inc., 2014. It is also possible for iPhones to encrypt iMessages which are text messages between iPhones), that would only be accessible between sender and recipient.

## **How Are Confidential Files Deleted?**

On most computers, using the Delete key to get rid of a file leaves virtually all of the file on the hard disk, where it can be retrieved easily by an inexpensive data recovery program. To dispose of confidential files, it is useful to use some form of secure deleting, such as one that involves repeatedly overwriting the old file with random characters.

## **How Are Computer Disks Discarded?**

From time to time, the news media report what has become a standard story: Someone sells or discards a computer on which confidential information is discovered. If a computer disk or other electronic storage medium stored confidential information, it should be completely degaussed or physically destroyed.

## **How Do You Guard Against Human Error in Handling Confidential Information?**

Most people who have been online for a while are familiar with the sudden surprise that comes with the realization: I just sent that message to the wrong person! When we communicate over the internet about confidential patient information, the price of human error can be steep. What procedures do you have in place to make sure that confidential information is not misaddressed?

## **How Do You Make Sure that Only the Intended Recipient Receives Your Confidential Information?**

Even when we have made sure that an e-mail containing confidential information is addressed to the right person, the right person's e-mail address may be used by more than one person. Sometimes partners or family members share an e-mail address. Even if the sharing is not routine, a friend or family member may monitor someone's e-mails while the person is temporarily disabled, ill, or on vacation.

## **Do Your Clients Clearly Understand the Ways in Which They Can or Can't Communicate with You via E-Mail, Text Message, or Other Digital Means?**

Each of us has our own way of approaching digital technology in our work with patients. As the examples at the beginning of the chapter illustrated, e-mail, videoconferencing, and other digital formats are wonderful resources. But they also have risks. What is important is that patients understand how a specific clinician uses e-mail or other methods of digital communication. Clear understanding can prevent problems like:

- A therapist gives a patient her e-mail address for anything important that the patient needs to communicate before the next session, which is two weeks later, and the patient begins sending 30 to 50 messages each day.
- A patient searching the Web to find an e-mail address for the therapist, finding it, and sending messages to that address, when in fact it is the address of another person with the same name.
- A patient finding an e-mail address for the therapist and using it to send messages between therapy sessions about material that is too difficult for the patient to say face-to-face, when the e-mail address is an old one that the therapist does not use anymore.
- A patient finding a therapist's e-mail address and using it to tell the therapist that the patient will be taking an overdose of sleeping pills to commit suicide later that night but that the therapist should respond only if the therapist thinks the patient is worth saving, and the e-mail account is one that the therapist checks only once a week.

## **Is Your Professional Website or the Website of the Clinic, Hospital, or Group Practice at Which You Work Accessible to People with Disabilities?**

Websites need to be accessible to those with visual, hearing, movement, or other disabilities.

## **If Your Website Includes a Function That Enables Patients to Communicate with You (e.g., By Signing On with a Username and Password), Has It Been Adequately Secured)?**

Many of the security measures you take will be versions of the steps you take to secure your personal computer and network, guarding against hackers, hijackers, malware, unintentional viewing of confidential material, and so on.

## **If You Use Social Networking Media, Such as Facebook, Twitter, Instagram, And So On, Does the Medium Form a Link Between You and Any of Your Patients or Your Patients' Family Members? If So, How, If at All, Does It Affect the Therapy or Your Relationships with Your Patients?**

Introducing new forms of relationships with patients should be done with thoughtfulness and care. Countless problems—and sometimes catastrophes—can be avoided if we ourselves avoid entering new domains in a thoughtless and careless way. Thinking through new forms of relationships in terms of our own theoretical orientation and approach, the individual patient, the available research, the practicalities involved, informed consent issues, documentation, and so on, can help us meet the highest ethical and clinical standards.

## **Are You Aware of the Relevant Laws, Regulations, and Guidelines Governing the Use of Digital Media in Providing Clinical Services?**

This area can be particularly complicated if you are in one state or province and the patient is in another state or province. Cross-jurisdictional provision of services may be authorized, limited to a certain period of time, or not allowed at all. One good step to take is to check with the licensing boards in both jurisdictions. The provider



of your professional liability policy may also provide helpful information and guidance. The company ensuring your work has an obvious interest in helping you avoid problems. The Association of State and Provincial Psychology Boards (ASPPB) announced the introduction of the Psychology Interjurisdictional Compact (PSYPACT), which creates a legal and defensible yet practical system for regulating and facilitating the use of telecommunications and temporary face-to-face practice across jurisdictional boundaries.

## **Are You Aware of Emerging Research on Clinical Services Offered Through Digital Media?**

Research in these areas continues to evolve, using increasingly sophisticated methodologies. It is important to keep up with new research, regulations, and policies related to providing services in the increasingly digital world.

## **Notes**

- <sup>1</sup> This section is adapted from Adames, H. Y., Chavez-Dueñas, & Pope, K. S. (2019, March 6). Targeted: Surviving social media attacks. *Inside Higher Education*. Retrieved from <https://www.insidehighered.com/advice/2019/03/06/how-respond-social-media-attacks-opinion>.

# **Chapter 25**

## **SEXUAL ATTRACTION TO PATIENTS, THERAPIST VULNERABILITIES, AND SEXUAL RELATIONSHIPS WITH PATIENTS**

The prohibition of engaging in sexual acts with a patient stands as one of our oldest ethical standards. This rule is older than the 2,500 year-old Hippocratic Oath, an oath of ethics named after the Greek physician who practiced around the fifth century B.C. The ancient code of the Nigerian healing arts also included an admonition not “to sex the patient” (Brodsky, 1989, p. 15).

Despite centuries of teaching and efforts at prevention, violations persist. Hollwich et al. (2015) note that “a substantial proportion of psychotherapists engage in sexual interactions with their clients .... Such behaviour contrasts significantly with the unanimous disapproval of TCS expressed in the literature ... as well as in professional ethical guidelines, codes and laws ...” (p. 1; see also Magiste, 2020; Millbank, 2020).

While it may be common for a clinician to experience feelings of sexual attraction toward a patient, having such feelings and acting on them is not the same thing. However, the assumption that feelings alone can lead to the behavior contributes to feelings of guilt among clinicians. For instance, the research reviewed in this chapter suggests that simply feeling attracted to a patient tends to make many of us uncomfortable. Sexual feelings and impulses can lead to fantasies that make us feel excited, aroused, anxious, guilty, or

confused. Sometimes these feelings can be hard for therapists to accept or control, let alone reveal to our supervisor and colleagues.

As a field, we continue to have a hard time facing honestly and realistically our attraction to patients as well as the temptation to act on such attraction. This chapter takes a look at this complex and emotionally charged area of ethics, including:

- How Modern Ethics Codes Address Therapist-Client Sex
- How Therapist-Client Sex Can Injure Clients
- Gender and Other Patterns of Perpetrators and Victim
- Common Scenarios of Therapist-Client Sex
- Therapist Risk Factors
- Why Do Therapists Refrain When They Are Tempted?
- Confronting Daily Issues
- Physical Contact with Clients
- Sexual Attraction to Clients
- When the Therapist Is Unsure What to do
- Working with Clients Who Have Been Sexually Involved with a Therapist
- Ethical Aspects of Rehabilitation
- Hiring, Screening, and Supervising
- Scenarios for Discussion

## **HOW MODERN ETHICS CODES ADDRESS THERAPIST-CLIENT SEX**

The topic of therapist-client sex was not mentioned in modern ethics codes until research began to show that many therapists were engaging in sex with their patients. Although the codes had not highlighted this particular form of patient exploitation by name, therapist-patient sex was indeed violating sections of the ethics codes prior to the 1970s. To illustrate, Rachel Hare-Mustin (1974), former

chair of the American Psychological Association's Ethics Committee, noted that the 1963 Ethical Standards of Psychologists of the APA contained standards that would prohibit therapist-patient sexual involvement. She wrote that in the light of "a review of principles relating to competency, community standards and the client relationship that genital contact with patients is ethically unacceptable" (p. 310). Sexual involvement with current clients/patients has been explicitly prohibited since 1977. As Hare-Mustin and others had shown, the prohibition had been implied by other standards before that time. Jean Holroyd, professor at the University of California-Los Angeles and senior author of the first national study of therapist-patient sex, explained that the 1977 code did not represent a change in the standards regarding sexual activities with patients as illustrated in the following exchange:

**Administrative Law Judge:** Was it [the 1977 ethics code] a codification of what was already the standard of practice?

**Holroyd:** Yes, it was making it very explicit in the ethics code.

**Administrative Law Judge:** What I am asking is whether or not the standard of practice prior to the inclusion of that specific section in the [1977] ethics code, whether or not that changed the standard of practice.

**Holroyd:** No, it did not change the standard of practice. The standard of practice always precluded a sexual relationship between therapist and patient.

**Administrative Law Judge:** Even though it was not expressed in the ethics codes?

**Holroyd:** From the beginning of the term psychotherapy with Sigmund Freud, he was very clear to prohibit it in his early publications (*In the Matter of the Accusation Against: Myron E. Howland*, 1980, p. 49–50).

The courts recognized the long history of the ban against therapist-patient sexual involvement. In the mid-1970s, New York Supreme Court Presiding Justice Markowitz noted the long history of professional agreement that therapist-patient sex harms patients: "Thus from [Freud] to the modern practitioner we have common

agreement of the harmful effects of sensual intimacies between patient and therapist” (*Roy v. Hartogs*, 1976, p. 590).

That this ban has stayed constant over such a long time and throughout so many diverse cultures reflects to some extent the recognition that sexual behavior with a patient places the patient at risk for serious harm.

The longstanding ethical prohibition, however, failed to prevent a significant number of therapists sexually exploiting their patients. Feminist psychologists were among the first to point out that psychotherapy with women was plagued with what would today be considered unethical sexual interactions between therapist and client (Brown, 2010; Chesler, 1972; Holroyd, 1983; Holroyd & Brodsky, 1977; Pope & Bouhoutsos, 1986; Vasquez & Vasquez, 2017).

Up until the mid-1960s, the understanding of therapist-client sexual involvement was informed mainly by theory, common sense, and individual case studies. It has only been after that period of awakening that a considerable body of diverse systematic investigations has been used to inform our understanding of this topic with empirical data. Some subsequent sections of this chapter summarize some of the findings. For more detailed presentations of that groundbreaking research, see Gabbard, 1989; Gabbard & Pope, 1989; Pope & Bouhoutsos, 1986; Pope, 1988, 1990a&b, 1994.

## **HOW THERAPIST-CLIENT SEX CAN INJURE CLIENTS**

Beginning with Masters and Johnson (1966, 1970, 1975), investigators examined how therapist-client sexual involvement affects clients (Ben-Ari & Somer, 2004; Bouhoutsos et al., 1983; Brown, 1988; Butler & Zelen, 1977; Feldman-Summers & Jones, 1984; Herman et al., 1987; Nachmani & Somer, 2007; Pope & Vetter, 1991; Somer & Saadon, 1999; Sonne & Jochai, 2014; Sonne et al., 1985; Vinson, 1987). Approaches to learning about effects included studies of clients who have returned to therapy with a subsequent therapist as well as those who undertook no further therapy after their sexual involvement with a therapist.

The consequences for clients who have been sexually involved with a therapist have been compared to those for matched groups of therapy clients who: (a) have not been sexually involved with a therapist; and (b) patients who have been sexually involved with a (non-therapist) physician. Subsequent treating therapists (of those clients who undertook a subsequent therapy), independent clinicians, and the clients themselves have evaluated the effects. To examine the impact of therapist-client sexual involvement, client data from different sources were collected including clinical interview, behavioral observation, and standardized psychological assessment instruments. These diverse systematic approaches have supplemented individual patients' first-hand accounts (Brodsky, 1989; Freeman & Roy, 1976; Noel & Waterson, 1992; Plaisil, 1985; Walker & Young, 1986). The consequences of sexual exploitation of clients by therapists tend to cluster into 10 very general categories including:

1. Ambivalence
2. Guilt
3. Emptiness and Isolation
4. Sexual Confusion
5. Impaired Ability to Trust
6. Confused Roles and Boundaries
7. Emotional Lability
8. Suppressed Rage
9. Increased Suicide Risk
10. Cognitive dysfunction, frequently in the areas of concentration and memory and often involving flashbacks, intrusive thoughts, unbidden images, and nightmares (Pope, 1988, 1989a).

## **GENDER AND OTHER PATTERNS OF PERPETRATORS AND VICTIMS**

Significant numbers of therapists have reported on anonymous surveys that they have become sexually involved with at least one

client. When the data from the first eight national self-report surveys published in peer-reviewed journals are pooled, 5,148 participants provided anonymous self-reports (Akamatsu, 1988; Borys & Pope, 1989; Holroyd & Brodsky, 1977; Pope, 1994; Pope et al., 1986, 1979, 1987). Each of the three professions—psychiatry, psychology, and social work—is represented by at least two studies conducted in different years.

According to these pooled data, about 4.4% of the therapists reported becoming sexually involved with a client. The gender differences are significant with 6.8% of male therapists and 1.6% of female therapists reported having engaged in sex with a client.

Data from these studies as well as others (e.g., reports by therapists working with patients who have been sexually involved with a prior therapist) suggest that therapist-patient sexual involvement resembles other forms of abuse such as rape and incest in that the perpetrators are overwhelmingly (though not exclusively) male and the victims are overwhelmingly (though not exclusively) female (Pope, 1989b). For example, Bouhoutsos et al. (1983) reported a study in which 92% of the cases of therapist-patient sex involved a male therapist and female patient. Gartrell et al. (1986), who reported the first national self-report study of sexual involvement between psychiatrists and their patients, found that 88% of the “contacts for which both the psychiatrist’s and the patient’s gender were specified occurred between male psychiatrists and female patients” (p. 1128).

Data based on therapists’ reports of engaging in sex with patients or on therapists’ work with patients who have been sexually exploited by a prior therapist have been supplemented with national survey data from patients who have been sexually involved with a therapist. In one study, about 2.19% of the men and about 4.58% of the women reported having become sexually involved with their own therapists (Pope & Feldman-Summers, 1992).

Yet another source of data (supplementing those provided through reports by subsequent therapists, therapists’ anonymous self-reports, and patients’ anonymous self-reports) is consistent with the significant gender differences. Data obtained from licensing disciplinary actions suggested that about 86% the therapist-patient

cases are those in which the therapist is male and the patient is female (Pope, 1993).

Although the significant gender difference in therapist-client sexual involvement has long been a focus of scholarship, it is still not well understood. Holroyd and Brodsky's report (Holroyd & Brodsky, 1977) of the first national study of therapist-patient sex concluded with a statement of major issues that had yet to be resolved: "Three professional issues remain to be addressed: (a) that male therapists are most often involved, (b) that female patients are most often the objects, and (c) that therapists who disregard the sexual boundary once are likely to repeat" (p. 849). Holroyd (1983) suggested that the significant gender differences reflected sex role stereotyping and bias: "Sexual contact between therapist and patient is perhaps the quintessence of sex-biased therapeutic practice" (p. 285).

Holroyd and Brodsky's landmark research (Holroyd & Brodsky, 1977) was followed by a second national study focusing on not only therapist-patient but also professor-student sexual relationships. In this study, Pope et al. (1979) concluded:

When sexual contact occurs in the context of psychology training or psychotherapy, the predominant pattern is quite clear and simple: An older, higher-status man becomes sexually active with a younger, subordinate woman. In each of the higher-status professional roles (teacher, supervisor, administrator, therapist), a much higher percentage of men than women engage in sex with those students or clients for whom they have assumed professional responsibility. In the lower-status role of student, a far greater proportion of women than men are sexually active with their teachers, administrators, and clinical supervisors (p. 687; see also Pope, 1989a).

Although statistical analyses of the first eight national self-report studies published in peer-reviewed journals reveal significant gender differences and also significant effects related to the year of the study (the pooled data suggest that each year, there are about 10% fewer self-reports of therapist-patient sex than the year before), there is no significant effect due to profession. According to these data, psychologists, psychiatrists, and social workers report engaging in sex with their patients at about the same rates. Apparent differences



are actually due to differing years in which the studies were conducted (there was a confounding correlation between the professions and the years they were studied). The statistical analysis tested the predictive power of each variable (profession and year) once the variance accounted for by the other variable had been subtracted. Year had significantly more predictive power once effects due to profession had been accounted for than the predictive power of profession once effects due to year had been accounted for. Once year of study is taken into account, significant differences between professions disappear.

Brodsky (1989) examined the various risk factors that have been hypothesized at one time or another to make some clients more vulnerable to sexual exploitation by a therapist. Her analysis led her not to the personal history or characteristics of the client but rather to the prior behavior of the therapist. The most effective predictor of whether a client will become sexually exploited by a therapist is whether that therapist has previously engaged in sex with another client.

With access to a considerable set of historical and actuarial data, the APA Insurance Trust (1990) revealed that “the recidivism rate for sexual misconduct is substantial” (p. 3). Holroyd and Brodsky’s landmark survey (Holroyd & Brodsky, 1977) found that 80% of the therapists who reported engaging in therapist-patient sexual activities indicated that they became involved with more than one patient. In 1997, the California Department of Consumer Affairs (1997) reported that according to their review of the available data “80% of the sexually exploiting therapists have exploited more than one client. In other words, if a therapist is sexually exploiting a client, chances are he or she has done so before” (p. 14). In a 2011 update, the department noted: “In recent years, aggressive prosecution of offending therapists—and passage of laws that facilitate the enforcement work of licensing boards—have helped to significantly reduce the number of such cases reported to the licensing boards” (California Department of Consumer Affairs, 2011).

[Table 25.1](#) presents additional information, based on a national study of 958 patients who had been sexually involved with a therapist (Pope and Vetter, 1991). In this study, 80% of the patients who had

become sexually involved with a therapist only after termination of the therapy were found to have been harmed.

**Table 25.1.** Characteristics of 958 Patients Who Had Been Sexually Involved with a Therapist.

Characteristics	Number	Percentage
Patient was a minor at the time of the involvement	47	5
Patient married the therapist	37	3
Patient had experienced incest or other child sex abuse	309	32
Patient had experienced rape prior to sexual involvement with therapist	92	10
Patient required hospitalization considered to be at least partially a result of the sexual involvement	105	11
Patient attempted suicide	134	14
Patient committed suicide	7	1
Patient achieved complete recovery from any harmful effects of sexual involvement	143	*17
Patient seen pro bono or for reduced fee	187	20
Patient filed formal (for example, licensing, malpractice) complaint	112	12

\* – Refers to 17% of the 866 patients who experienced harm. Source: Adapted from Pope, K. S. & Vetter, V. A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy: Theory, Research, Practice, Training*, 28 (3), 429–438. Available at <http://kspope.com>. Copyright 1991 by the American Psychological Association (APA). Adapted with permission.

Five percent of the patients described in [Table 25.1](#) were minors at the time that they were sexually involved with a therapist. This finding underscores an important aspect of therapist-patient sex. Although much of the literature on this topic seems to assume that the patient is an adult, this is not always the case. In a national study

focusing exclusively on minor patients who were sexually involved with a therapist, most (56%) were female (Bajt & Pope, 1989). The average age of these girls who were sexually involved with a therapist was 13, and the range was from age 17 down to age 3. The average age of the male minor patients was 12, ranging from 16 down to 7.

## COMMON SCENARIOS OF THERAPIST-CLIENT SEX

It is useful and important for therapists to be aware of the common scenarios in which therapists sexually exploit their patients. Pope and Bouhoutsos (1986, p. 4) presented 10 of the most common scenarios:

1. *Role Trading*. Therapist becomes the “patient” and the wants and needs of the therapist become the focus.
2. *Sex Therapy*. Therapist fraudulently presents therapist-patient sex as valid treatment for sexual or related difficulties.
3. *As If ...* Therapist treats positive transference as if it were not the result of the therapeutic situation.
4. *Svengali*. Therapist creates and exploits an exaggerated dependence on the part of the patient.
5. *Drugs*. Therapist uses cocaine, alcohol, or other drugs as part of the seduction.
6. *Rape*. Therapist uses physical force, threats, and/or intimidation.
7. *True Love*. Therapist uses rationalizations that attempt to discount the clinical/professional nature of the professional relationship and its duties.
8. *It Just Got Out of Hand*. Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect.
9. *Time Out*: Therapist fails to acknowledge and take account of the fact that the therapeutic relationship does not cease to exist between scheduled sessions or outside the therapist’s office.

10. *Hold Me*. Therapist exploits patient's desire for non-erotic physical contact and possible confusion between erotic and non-erotic contact.

It is important to emphasize, however, that these are only general descriptions of some of the most common patterns, and many instances of therapist-patient sexual involvement will not fall neatly into these categories.

## **THERAPIST RISK FACTORS**

While emphasizing that therapist risk factors do not release therapists from the ethical responsibility to ensure exploitation of the client does not occur via therapist-patient sex involvement and that it is the *therapist* (never the patient) who “always bears the professional burden in this regard” (p. 518), Norris et al. (2007; see also Pope, 1994; Pope & Bouhoutsos, 1986; Subotsky, Bewley & Crowe, 2010), call our attention to some of the major therapist risk factors for the therapist engaging in sex with the client. Here are a few:

- Life crises
- Employment transition (retirement, transfer, promotion, termination)
- Illness
- Loneliness and the impulse to confide
- Idealizing the client
- Self-esteem issues (pride, shame, and envy)
- Problems setting limits
- Denial (e.g., “This couldn’t happen to me”)

Ethical awareness includes remaining alert to these and other factors that may make it more likely that we will act on our sexual feelings about clients—and taking actions to address these factors promptly and effectively to prevent client exploitation. When we spot both our own sexual attraction to a client and our risk factors early, we can

head off potential ethical violations before we begin using the common rationalization that therapist-client sex will not harm and may actually benefit the client (Dahlberg, 2014).

## WHY DO THERAPISTS REFRAIN WHEN THEY ARE TEMPTED?

Although our apparent insights into our own motives as therapists may be questionable at best, it is worth asking, *Why do the overwhelming majority of therapists avoid sexually exploiting patients?* [Table 25.2](#) presents the answers to this question as provided by therapists in two national studies, including one of psychologists and the other of social workers.

**Table 25.2.** Reasons Therapists Offer for Refraining from Sexual Involvement with Clients.

Reasons	Social Workers	Psychologists
Unethical	210	289
Countertherapeutic/exploitative	130	251
Unprofessional practice	80	134
Against therapist's personal values	119	133
Therapist already in a committed relationship	33	67
Feared censure/loss of reputation	7	48
Damaging to therapist	39	43
Disrupts handling transference/countertransference	10	28
Fear of retaliation by client	2	19
Attraction too weak/short-lived	16	18
Illegal	14	13
Self-control	8	8
Common sense	7	8
Miscellaneous	13	3

Reasons	Social Workers	Psychologists
<p><i>Sources:</i> Adapted from Pope, K. S., Keith-Spiegel, P., &amp; Tabachnick, B. G. (1986). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. <i>American Psychologist</i>, 41(2), 147–158. Available at <a href="http://kspope.com">http://kspope.com</a>. Copyright 1986 by the American Psychological Association (APA). Adapted with permission. Bernsen, A., Tabachnick, B.G., and Pope, K.S. (1994). National survey of social workers' sexual attraction to their clients: Results, implications, and comparison to psychologists. <i>Ethics &amp; Behavior</i>, 4(4), 369–388. Available at <a href="http://kspope.com">http://kspope.com</a>. Copyright 1994 by the Routledge/Taylor &amp; Francis. Adapted with permission.</p>		

## CONFRONTING DAILY ISSUES

The issue of therapist-client sexual involvement reflects some major themes of this book: (1) the great vulnerability of the client highlights the power of the therapist; (2) the professional responsibility the therapist has not to take advantage of the power they have; and (3) the trust that characterize the client's relationship with the therapist (see [Chapter 5](#)). In many ways, the therapist's caring may be crucial in protecting against the temptation to exploit the client.

The issue of therapist-client sexual involvement illustrates a fourth and fundamental theme of this book. This fourth theme underscores how ethics is not mindlessly following a list of dos and don'ts but always involves active awareness, thinking, and questioning. There is, of course, a clear prohibition: avoid any sexual involvement with clients. No cause, situation, or condition could ever legitimize or excuse such involvement with any client (see, e.g., Gabbard & Pope, 1989). "Context is important for understanding the transgression of sexual boundaries in therapy, but this behavior is unethical in any context" (Gutheil & Brodsky, 2008, p. 175). The prohibition stands as a fundamental ethical mandate, no matter what rationalizations are made. Taking this prohibition seriously, however, marks the initial rather than the final phase in meeting our ethical responsibilities in this area. In the next sections we address several issues associated with sexual exploitation of clients that we must name, confront, and struggle with.

## PHYSICAL CONTACT WITH CLIENTS

The very topic of therapist-client sexual involvement as well as the concern that we may be subject to an ethics complaint or malpractice suit may make many of us very nervous. We may go to great lengths to ensure that we maintain physical distance from our clients and under no circumstances touch them for fear that this might be misconstrued. A similar phenomenon seems to be occurring in regard to increasing public acknowledgment of child sexual abuse: Adults may be reluctant to hold children and engage in nonsexual touch that is a normal part of life. Hence, exploring whether there is evidence that nonsexual touching of patients is actually associated with therapist-client sexual involvement is important. Holroyd and Brodsky (1980) examined this question and found no indications that physical contact with patients made sexual contact more likely. They did find evidence that differential touching of male and female clients (i.e., touching clients of one gender significantly more than clients of the other gender) was associated with therapist-patient sexual involvement:

Erotic contact not leading to intercourse is associated with older, more experienced therapists who do not otherwise typically touch their patients at a rate different from other therapists (except when mutually initiated). Sexual intercourse with patients is associated with the touching of opposite-sex patients but not same-sex patients. It is the differential application of touching—rather than touching per se—that is related to intercourse (p. 810).

If the therapist is personally comfortable engaging in non-sexual physical contact with a client, the following is important to keep in mind: (a) maintains a theoretical orientation for which therapist-client contact is not antithetical; (b) has competence (education, training, and supervised experience) in the use of touch; and (c) then decides on whether or not to make physical contact with a particular client, which must be based on a careful evaluation of the clinical needs of the client at that moment in the context of any relevant cultural and other contextual factors. When solidly based on clinical needs and a clinical rationale, touch can be exceptionally caring, comforting, reassuring, or healing (e.g., a hug or hand on shoulder). When not justified by clinical need and therapeutic rationale,

nonsexual touch can also be experienced as intrusive, frightening, disorienting, or demeaning. The decision must always be made carefully and in full awareness of the power of the therapist and the trust (and vulnerability) of the client. For discussions of various approaches to non-erotic touch in psychotherapy, please see Ashieri (2009), Bonitz (2008), Downey (2001), Fuller (2006), Kepner (2001), McNeil-Haber (2004), Phelan (2009), Pope, Sonne et al. (2006), Stenzel and Rupert (2004), Wright (2020), and C. Young (2007).

Our responsibility to be sensitive to the issues of non-sexual touch and explore them carefully extends to other therapeutic issues conceptually related to the issue of therapist-client sexual involvement. Our unresolved concerns with therapist-client sexual involvement may prompt us to respond to the prospect of nonsexual touching either in a phobic manner—avoiding in an exaggerated manner any contact or even physical closeness with a client—or in a counterphobic way—engaging in apparently nonsexual touching such as handshakes and hugs as if to demonstrate that we are very comfortable with physical intimacy and experience no sexual impulses. These unresolved concerns can also elicit phobic or counterphobic behavior in other areas, such as the clinician’s initiating discussion or focusing on sexual issues to an extent that is not based on the client’s clinical needs. To respond ethically, authentically, and therapeutically to such issues, we must confront our own unresolved feelings of sexual attraction to our clients.

## **SEXUAL ATTRACTION TO CLIENTS**

Sexual attraction to clients seems to be a prevalent experience that evokes negative reactions. National survey research suggests that over 4 out of 5 psychologists (87%) and social workers (81%) report having experienced sexual attraction to at least 1 client (Bernsen et al., 1994; Pope et al., 1986). As [Table 25.3](#) illustrates, therapists identify many aspects of patients that, according to the therapists, are the source or focus of the attraction. Yet simply experiencing the attraction (without necessarily even feeling tempted to act on it) causes most of the therapists who report such attraction (63% of the



psychologists and 51% of the social workers) to experience feelings of guilt, anxiety, or confusion about the attraction.

**Table 25.3.** Characteristics of Clients to Whom Therapists Are Attracted.

<b>Characteristics</b>	<b>Social Workers</b>	<b>Psychologists</b>
Physical attractiveness	175	296
Positive mental/cognitive traits or abilities	84	124
Sexual	40	88
Vulnerabilities	52	85
Positive overall character/personality	58	84
Kindness	6	66
Fills therapist's needs	8	46
Successful	6	33
"Good patient"	21	31
Client's attraction	3	30
Independence	5	23
Other specific personality characteristics	27	14
Resemblance to someone in therapist's life	14	12
Availability (client unattached)	0	9
Pathological characteristics	13	8
Long-term client	7	7
Sociability (sociable, extroverted)	0	6
Miscellaneous	23	15
Same interests/philosophy/background as therapist	10	0

Characteristics	Social Workers	Psychologists
<p><i>Sources:</i> Adapted from Pope, K. S., Keith-Spiegel, P., &amp; Tabachnick, B. G. (1986). Sexual attraction to clients: The human therapist and the (sometimes) inhuman training system. <i>American Psychologist</i>, 41(2), 147–158. Available at <a href="http://kspope.com">http://kspope.com</a>. Copyright 1986 by the American Psychological Association (APA). Adapted with permission. Bernsen, A., Tabachnick, B.G., &amp; Pope, K.S. (1994). National survey of social workers' sexual attraction to their clients: Results, implications, and comparison to psychologists. <i>Ethics &amp; Behavior</i>, 4(4), 369–388. Available at <a href="http://kspope.com">http://kspope.com</a>. Copyright 1994 by the Routledge/Taylor &amp; Francis. Adapted with permission.</p>		

That sexual attraction causes such discomfort among so many psychologists and social workers may be a significant reason why graduate training programs and internships tend to neglect providing training in this important area. To illustrate, only 9% of psychologists and 10% of social workers surveyed in these national studies reported that their formal training on the topic in graduate school and internships had been adequate. A majority of psychologists and social workers reported receiving no training about attraction.

This discomfort may also be a significant reason that scientific and professional books seem to neglect this topic:

In light of the multitude of books on human sexuality, sexual dynamics, sex therapies, unethical therapist-patient sexual contact, management of the therapist's or patient's sexual behaviors, and so on, it is curious that sexual attraction to clients per se has not served as the primary focus of a wide range of texts. The professor, supervisor, or librarian seeking books that turn their *primary* attention to exploring the therapist's *feelings* in this regard would be hard pressed to assemble a selection from which to choose an appropriate course text. If someone unfamiliar with psychotherapy were to judge the prevalence and significance of therapists' sexual feelings on the basis of the books that focus exclusively on that topic, he or she might conclude that the phenomenon is neither widespread nor important (Pope, Sonne, & Holroyd, 1993, p. 23).

These and similar factors may form a vicious circle: Discomfort with sexual attraction may have fostered an absence of relevant textbooks and graduate training; in turn, an absence of relevant textbooks and programs providing training in this area may sustain or intensify discomfort with the topic (Pope et al., 1993). Thus, the avoidance of the topic may produce a real impact in the clinician's ability and skills to handle this common experience ethically.

These studies reveal significant gender effects in reported rates of experiencing sexual attraction to a patient. About 95% of the male psychologists and 92% of the male social workers compared with 76% of the female psychologists and 70% of the female social workers reported experiencing sexual attraction to a patient. Research suggests that male therapists are significantly more likely to become sexually involved with their patients, and to experience sexual attraction to their patients.

Additionally, national surveys indicate that a sizable minority of therapists carry with them—in the physical absence of the client—sexualized images of the client and that a significantly greater percentage of male than of female therapists experience such cognitions. About 27% of male psychologists and 30% of male social workers, compared with 14% of female psychologists and 13% of female social workers, reported engaging in sexual fantasies about a patient while engaging in sexual activity with another person (not the patient). National survey research has found that 46% of psychologists reported engaging in sexual fantasizing (regardless of the occasion) about a patient on a rare basis and that an additional 26% reported more frequent fantasies of this kind (Pope et al., 1987), and 6% of clinicians reported sharing their sexual fantasies with their patients (Pope & Tabachnick, 1993). Such data may be helpful in understanding not only how therapists experience and respond to sexual feelings but also how therapists and clients represent (e.g., remember, anticipate, think about, fantasize about) each other when they are apart and how this affects the psychotherapeutic process and outcome (see Geller et al., 1981–1982; Orlinsky & Geller, 1993; Pope & Brown, 1996; Pope & Singer, 1978; Pope, Sonne, & Greene, 2006).

For any clinicians who experience sexual attraction to a client, it is important to recognize that research suggests this is a common experience (Sonne & Jochai, 2014). Put succinctly, to feel attraction to a client is not unethical; however, our ethical responsibility requires us to acknowledge and address the attraction promptly, carefully, and adequately. Understanding the phenomenon of attraction has implications for training, supervision, and consultation (Giovazolias & Davis, 2001; Pope, Sonne et al., 2006; Pope et al., 1993). For some of us, consultation with respected colleagues will be useful. For others, obtaining formal consultation (if licensed; supervision if not) for our work with that client may be necessary. For still others, entering or re-entering psychotherapy can be helpful.

## **WHEN THE THERAPIST IS UNSURE OF WHAT TO DO**

What can the therapist do when they do not know what to do? The book *Sexual Feelings in Psychotherapy* (Pope et al., 1993), suggests 10 actions to take in such daunting situations, which are summarized below. A repeated theme of the *Sexual Feelings in Psychotherapy* book is that therapists lack easy, one-size-fits-all answers to what sexual feelings about patients mean or their implications for therapy. Different theoretical orientations provide different, sometimes opposing ways of approaching such questions. Each person and situation are unique. Thus, therapists must explore and achieve a working understanding of their own unfolding, evolving feelings and the ways in which these feelings may play a helpful role in deciding what to say or do next. Cookbook approaches can block rather than foster this process.

The approach outlined here places fundamental trust in the individual therapist, adequately trained and consulting with others, to draw their own conclusions. Almost without exception, therapists learn at the outset the fundamental resources for helping themselves explore problematic situations. Depending on the situation, they may introspect, study the available research and clinical literature, consult, seek supervision, or begin or resume personal therapy. But sometimes, even after the most sustained exploration, the course is

not clear. The therapist's best understanding of the situation suggests a course of action that seems productive yet questionable and perhaps potentially harmful. To refrain from a contemplated action may cut the therapist off from legitimately helpful spontaneity, creativity, intuition, and ability to respond effectively to the patient's needs. But engaging in the contemplated action may lead to disaster and harm. When reaching such an impasse, therapists may find it useful to consider the potential intervention in the light of these 10 considerations:

## **1.Fundamental Prohibition**

The first action in this process is to consider whether the contemplated option is consistent with the fundamental prohibition against therapist–client sexual involvement. Therapists must never violate the special trust between clinician and client. If the considered course of action includes any form of sexual involvement with a patient, it must be rejected.

## **2.Slippery Slope**

The second consideration may demand deeper self-knowledge and self-exploration. Is the contemplated course of action likely to lead to or create a risk for sexual involvement with the patient? The contemplated action may seem unrelated to any question of sexual exploitation of a patient. Yet depending on the personality, strengths, and weaknesses of the therapist, the considered action may constitute a subtle first step on a slippery slope. In most cases, the therapist alone can address this consideration if they are willing and ready to be honest with themselves.

## **3.Consistency of Communication**

The third consideration invites the clinician to review the course of therapy from the start to the present: Has the therapist consistently, directly, and unambiguously communicated to the client that sexual involvement cannot and will not occur, and is the contemplated action consistent with that communication? Does the contemplated action needlessly cloud the clarity of that communication? The

human therapist may be intensely tempted to act in ways that stir the patient's sexual interest or respond in a self-gratifying way to the client's sexuality. Does the contemplated action represent, however subtly, a turning away from the legitimate goals of therapy?

## **4. Clarification**

The fourth consideration invites therapists to ask if the contemplated action would be better postponed until sexual and related issues have been clarified. Assume, for example, that a therapist's theoretical orientation does not preclude physical contact with clients and that a client has asked that each session conclude with a reassuring hug between therapist and client. Such ritualized hugs could raise complex questions about their meaning for the client, their impact on the relationship, and how they might influence the course and effectiveness of therapy. It may be important to clarify such issues with the client before making a decision to conclude each session with a hug.

## **5. Client's Welfare**

The fifth consideration is one of the most fundamental touchstones of all therapy: Is the contemplated action consistent with the client's welfare? The therapist's feelings may become so intensely powerful that they may create a context in which the client's clinical needs may blur or fade out altogether. The client may express wants or feelings with great force. The legal context—with the litigiousness that seems so prevalent in current society—may threaten the therapist in a way that makes it difficult to keep a clear focus on the client's welfare. Despite such competing factors and complexities, it is crucial to assess the degree to which any contemplated action supports, is consistent with, is irrelevant to, or is contrary to the patient's welfare.

## **6. Consent**

The sixth consideration is yet another fundamental touchstone of therapy: Is the contemplated action consistent with the basic right to informed consent of the client?

## **7. Adopting the Client's View**

The seventh consideration urges the therapist to empathize imaginatively with the client: How is the client likely to understand and respond to the contemplated action?

Therapy is one of many endeavors in which exclusive attention to theory, intention, and technique may distract from other sources of information, ideas, and guidance. Therapists in training may cling to theory, intention, and technique as a way of coping with the anxieties and overwhelming responsibilities of the therapeutic venture.

Seasoned therapists may rely almost exclusively on theory, intention, and technique out of learned reflex, habit, and the sheer weariness that approaches burnout. There is always risk that the therapist will fall back on repetitive and reflexive responses that verge on stereotype. Without much thought or feeling, the anxious or tired therapist may, if analytically minded, answer a client's question by asking why the client asked the question; if holding a client-centered orientation, may simply reflect or restate what the client has just said; if gestalt-trained, may ask the client to say something to an empty chair; and so on.

One way to help avoid responses that are driven more by anxiety, fatigue, or other similar factors is to consider carefully how the therapist would think, feel, and react if he or she were the client. Regardless of the theoretical soundness, intended outcome, or technical sophistication of a contemplated intervention, how will it likely be experienced and understood by the client? Can the therapist anticipate at all what the client might feel and think? The therapist's attempts to try out, in his or her imagination, the contemplated action and to view it from the perspective of the client may help prevent, correct, or at least identify possible sources of misunderstanding, miscommunication, and failures of empathy (Pope et al., 1993, p. 185–186).

## **8. Competence**

The eighth consideration is one of competence. Consider whether the therapist is competent to carry out the contemplated intervention? Ensuring that a therapist's education, training, and supervised

experiences are adequate and appropriate for their work is a fundamental ethical responsibility.

## **9.Uncharacteristic Behaviors**

The ninth consideration involves becoming alert to unusual actions. For instance, does the contemplated action fall substantially outside the range of the therapist's usual behaviors? That an action is unusual does not, of course, mean that something is necessarily wrong with it. Creative therapists occasionally try creative interventions, and it is unlikely that even the most conservative and tradition-bound therapist conducts therapy the same way all the time. However, possible actions that are considerably outside the therapist's general approaches likely warrant special attention, reflection, and consideration.

## **10.Consultation**

The tenth consideration concerns secrecy. A fundamental question is whether the therapist has a need not to discuss the contemplated action with a colleague, consultant, or supervisor? Therapists' reluctance to disclose an action to others is a red flag to possibly inappropriate action. Therapists may consider any possible action in the light of this question: If they took this action, would they have any reluctance for all of their professional colleagues to know that they had taken it? If the response is yes, the reasons for the reluctance warrant examination. If the response is no, it is worth considering if one has adequately taken advantage of the opportunities to discuss the matter with a trusted colleague. If discussion with a colleague has not helped to clarify the issues, consultation with additional professionals, each of whom may provide different perspectives and suggestions, may be useful.

## **WORKING WITH CLIENTS WHO HAVE BEEN SEXUALLY INVOLVED WITH A THERAPIST**

It is likely that any therapist, counselor, or trainee reading this book will encounter clients who have been sexually victimized by a prior therapist. A national study of 1,320 psychologists found that 50%



reported working with at least 1 client who, in the therapist's professional opinion, had been a victim of therapist-client sexual involvement (Pope & Vetter, 1991). About 4% reported working with at least 1 client who, in the therapist's opinion, had made false allegations about sex with a prior therapist.

Given the probability of working with clients who have been sexual exploited by their therapists, it is crucial that clinicians be genuinely knowledgeable about this area. Clients who have been sexually exploited tend to be exceptionally vulnerable to revictimization when their clinical needs are not recognized. Special methods and considerations for providing therapeutic services to victims of therapist-patient sexual involvement have been developed and continue to evolve (Pope, 1994). One of the first actions toward gaining competence in this area is recognition of the diverse and sometimes extremely intense reactions that encountering a client who reports sexual involvement with a former therapist can evoke in the subsequent therapist. [Table 25.4](#) identifies some of the most common reactions.

**[Table 25.4.](#)** Ten Common Therapists' Reactions to Victims of Therapist-Patient Sexual Involvement.

<b>Disbelief and Denial</b>	The tendency to reject reflexively—without adequate data gathering—allegations about therapist-patient sex (because, for example, the activities described seem outlandish and improbable)
<b>Minimization of Harm</b>	The tendency to assume reflexively—without adequate data gathering—that harm did not occur or that, if it did, the consequences were minimally, if at all, harmful
<b>Making the Patient Fit the Textbook</b>	The tendency to assume reflexively—without adequate data gathering and examination—that the patient must inevitably fit a particular schema
<b>Blaming the Victim</b>	The tendency to attempt to make the patient responsible for enforcing the therapist's professional responsibility to refrain from engaging in sex with a patient and holding the patient responsible for the therapist's offense

<b>Sexual Reaction to the Victim</b>	The clinician's sexual attraction to or feelings about the patient; such feelings are normal but must not become a source of distortion in the assessment process
<b>Discomfort at the Lack of Privacy</b>	The clinician's (and sometimes patient's) emotional response to the possibility that under certain conditions (for example, malpractice, licensing, or similar formal actions against the offending therapist; a formal review of assessment and other services by the insurance company providing coverage for the services) the raw data and the results of the assessment may not remain private
<b>Difficulty "Keeping the Secret"</b>	The clinician's possible discomfort (and other emotional reactions) when he or she has knowledge that an offender continues to practice and to victimize other patients but cannot, in the light of confidentiality or other constraints, take action to intervene
<b>Intrusive Advocacy</b>	The tendency to want to guide, direct, or determine a patient's decisions about what actions to take or what actions not to take in regard to a perpetrator
<b>Vicarious Helplessness</b>	The clinician's discomfort when a patient who has filed a formal complaint seems to encounter unjustifiable obstacles, indifference, lack of a fair hearing, and other responses that seem to ignore or trivialize the complaint and fail to protect the public from offenders
<b>Discomfort with Strong Feelings</b>	The clinician's discomfort when experiencing strong feelings (for example, rage, neediness, or ambivalence) expressed by the patient and focused on the clinician
<p><i>Source: Sexual Feelings in Psychotherapy: Explorations for Therapists and Therapists-in-Training (pp. 241–261), by K. S. Pope, J. L. Sonne, &amp; J. Holroyd, 1993, Washington, DC: American Psychological Association. Copyright 1993 American Psychological Association. Adapted with permission.</i></p>	

Awareness of these reactions can prevent them from blocking the therapist from rendering effective services to the patient. The

therapist can be alert for such reactions and sort through them should they occur. In some instances, the therapist may seek consultation to help gain perspective and understanding.

## **ETHICAL ASPECTS OF REHABILITATION**

Unfortunately, therapists and counselors may act in ways that discount the harm done by perpetrators of therapist–patient sex, obscure the responsibilities of perpetrators, and enable perpetrators to continue—sometimes after a period of suspension—victimizing clients (Brotsky, 1989; Gabbard, 1989). The rehabilitation methods by which perpetrators are returned to practice highlight many of this book’s themes and pose difficult ethical dilemmas. Pope (1990a, 1990b, 1990c, 1991) reviewed some of the crucial but difficult ethical questions facing therapists and counselors considering rehabilitation efforts; they are summarized next.

### **1.Competence**

Does the clinician who is implementing the rehabilitation plan possess demonstrable competence in the areas of rehabilitation and therapist–patient sexual involvement?

Has the rehabilitation method the clinician uses been adequately validated through independent studies? Obviously, a clinician who was claiming an effective “cure” for pedophilia, kleptomania, dyslexia, panic attacks, or a related disorder would need to present the scientific evidence for the intervention’s effectiveness. Ethical standards for claims based on evidence in this area—particularly given the risks for abuse to which future patients may be exposed—should not be waived. Such evidence must meet the customary requirement of publication in peer-reviewed scientific or professional journals.

Research results that survive and benefit from this painstaking process of systematic review created to help ensure the scientific integrity, merit, and trustworthiness of new findings may be less likely (than data communicated *solely* through press conferences, popular lectures, books, workshops, and television appearances) to contribute to ... “social-science fiction”(Pope, 1990b, p. 482).

We have been unable to locate any independently conducted, replicated research published in peer-reviewed scientific or professional journals that supports the effectiveness of rehabilitation efforts in this area.

## **2.Informed Consent**

Whether the rehabilitation technique is viewed as an intervention of proven effectiveness (through independently conducted research trials) or as an experimental research trial for a promising approach, have those who are put at risk for harm been adequately informed and have they been given the option of not assuming the risk, should the rehabilitation fail to be 100% effective?

## **3.Assessment**

Do the research trials investigating the potential effectiveness of the rehabilitation method meet at least minimal professional standards? For example, is the research conducted independently? We are rarely disinterested judges of the profundity, effectiveness, and near perfection of our own work.

A more complex requirement concerns whether the base rate of discovery of abuse is adequately taken into account in conducting and reporting the results of experimental trials of rehabilitation efforts. Perpetrators may continue to engage in sexual involvement with clients during (or after) rehabilitation efforts, even when they are supervised (see Brodsky, 1989). The abuse may come to the light only if the client reports it. Yet the base rate of such reports by clients is quite low. Surveys of victims suggest that only about 5% report the behavior to a licensing board (see Pope & Vetter, 1991). The percentage appears to be significantly lower when the number of instances of abuse estimated from anonymous surveys of clinicians (who report instances in which they have engaged in abuse) is compared with complaints filed with licensing boards, ethics committees, and the civil and criminal courts. Using the higher 5% reporting estimate, assume that you conduct research in which a licensing board refers 10 offenders to you for rehabilitation. You work with the offenders for several years and are convinced that you have completely rehabilitated all 10. You assure the licensing board

of your complete confidence that none of the 10 will pose any risk to future clients. But also assume that your rehabilitation effort fails miserably. All 10 offenders will engage in sex with a future client. What are the probabilities that any of the 10 future abuse victims will file a complaint? If each client has only a 5% probability of reporting the abuse, there is a 59.9% probability that none of the 10 will file a complaint. Thus, there is close to a 60% chance that these research trials, even if independently evaluated, will appear to validate your approach as 100% effective when in fact it was 100% ineffective. As can be ascertained from this example, if ignored in conducting and reporting research, the low base rate can make a worthless intervention appear completely reliable.

## **4. Power and Trust**

The ethics of psychotherapy and counseling are inherently related to power and trust. How are these factors relevant to the dilemmas of rehabilitation?

If a judge were convicted of abusing the power and trust inherent in the position of judgeship by allowing bribes to determine the outcome of cases, numerous sanctions, both criminal and civil, might follow. However, even after the judge paid the debt due to society by the abuse of power and trust, the judge would not be allowed to resume the bench, regardless of any “rehabilitation.”

Similarly, if a preschool director were discovered to have sexually abused students, they would likely face both civil and criminal penalties. The director might undergo extensive rehabilitation efforts to help reduce the risk that they would engage in further abuse of children. However, regardless of the effectiveness of the rehabilitation efforts, the state would not issue the individual a new license to found and direct another preschool.

Neither of these two offenders would necessarily be precluded from practicing their professions. The former judge and preschool director, once rehabilitated, might conduct research, consult, publish, lecture, or pursue other careers within the legal and educational fields. However, serving as judge or as preschool director are positions that involve such trust by both society and the individuals subject to their immediate power that the violation of

such an important and clearly understood prohibition against abuse of trust (and power) precludes the opportunity to hold such special positions within the fields of law and education.

The helping professions must consider the ethical, practical, and policy implications of allowing and enabling offenders to resume the positions of special trust that they abused. Do psychotherapy and counseling involve or require a comparable degree of inviolable trust, from individual clients and from the society more generally, and ethical integrity as the positions of judge and preschool director within the legal and educational fields?

## **HIRING, SCREENING, AND SUPERVISING**

Those who work within health maintenance organizations, hospitals, and other structures hiring clinicians have a responsibility to attend carefully to the risks that staff may sexually exploit clients. Carefully structured and adequately comprehensive forms and procedures (verifying education, supervision, licensure, employment, history of licensing or ethics complaints, etc.) for screening potential personnel, establishing and monitoring policies prohibiting sex with clients, and so on have long been advocated as important in minimizing the risk that organizational personnel will sexually exploit clients (see Pope, 1994; Pope and Bouhoutsos, 1986). More recently, however, the usefulness of such forms and procedures that operationally define screening procedures and policy implementation has been recognized as an important component of malpractice risk management, not only in hospitals but also in clinics, group practices, and similar settings. As defense attorney Brandt Caudill (1993) stated:

Given the current state of the law, it seems clear that psychologists must assume that they may be sued if a partner, employee, or supervisee engages in a sexual relationship with a patient, because it appears that the courts are moving to the position that a sexual relationship between a therapist and a patient is a recognizable risk of employment which would be within the scope of the employer–employee relationship (p. 4–5).

It may be very difficult for employers and those with administrative or clinical supervisory responsibilities to argue successfully that the sexual relationship involving a supervisee or employee was not within the scope of employment. As one court held:

We believe that the nature of the work performed by a therapist is substantially different than that of a day-care teacher as in *Randi F.* or a security guard as in *Webb* or a medical doctor as in *Hoover* so that a therapist who engages in sexual relations with a patient could not be said, as a matter of law, to have acted outside the scope of his employment (*St. Paul Fire & Marine Insurance Company v. Downs*, 1993, p. 344).

Illinois is an example of a state that enacted legislation making an employer liable when it knows or should reasonably know that a therapist–employee engaged in sexual contact with a patient (Ill. Rev. Stat., 1991, chap. 70, para. 803).

Here are some actions that have been suggested previously as useful in addressing these issues when screening job applicants (Pope, 1994; Pope & Bouhoutsos, 1986):

- Discuss with the applicant any formal or informal training experiences in such areas as identifying and addressing both the clinician's and the client's sexual feelings. Are there classroom teachers, practicum supervisors, or previous employers who have provided such training and could be contacted to obtain information?
- Use an employment application form that traces back in sufficient detail from the present to college graduation. Ensure that there are no gaps in education or employment that are not clearly explained in writing.
- Provide a form for release of information that will enable the prospective employer to check with each setting of previous training, employment, or experience.
- Check with supervisors at any institutions at which the applicant obtained graduate training.
- Verify that the applicant was awarded all degrees claimed on the application form.

- Verify that any internships, practica, or postdocs were successfully completed. Check with a supervisor at each site.
- Check for information with each state that has issued the applicant a clinical license. Verify that no license has been revoked or subject to disciplinary procedures in which the applicant was found to have engaged in prohibited activities.
- Obtain a copy of all significant certifications.
- Obtain a copy of the applicant's resume or curriculum vitae. Ensure that it is consistent with the responses to the application form described in the second bullet point.
- Ensure that the applicant fully understands the explicit policies of the organization in regard to prohibited activities with clients and that he or she signs an agreement to that effect.

If entering into a sexual relationship with a client must be avoided, what about entering into a nonsexual relationship? The next chapter focuses on these nonsexual dual and multiple relationships.



# SCENARIOS FOR DISCUSSION

It has been an extremely demanding week, and you are looking forward to watching a new movie with your life partner. The theater is packed, but you find two seats on the aisle not too close to the screen. You feel great to have left work behind you at the office and to be with your partner for an evening on the town. As the lights go down, you lean over to give your partner a passionate kiss. For some reason, while kissing, you open your eyes and notice that, sitting in the seat on the other side of your partner and watching you, is a therapy client who just that afternoon had revealed an intense sexual attraction to you.

- What feelings does this scenario evoke in you?
- If you were the therapist, what, if anything, would you say to the client at the time of this event? What would you say during the next therapy session?
- How would the client's presence affect your subsequent behavior at the theater?
- How might this event affect the therapy and your relationship with the client?
- What, if anything, would you say to your partner—either at the theater or later—about what had happened? Are there any circumstances under which you would call the client before the next scheduled appointment to discuss the matter?
- Imagine that during a subsequent therapy session, the client begins asking about whom you were with at the theater. How would you feel? What would you say?
- What if the client were a business client of your partner (or knew your partner in another context) and they begin talking before the movie? What feelings would this discovery evoke in you? What would you consider in deciding how to handle this matter?
- To what extent do you believe that therapists should be free to be themselves? To what extent should they behave in public

as if a client might be observing them?

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During your first session with a new client, he tells you that he has always been concerned that his penis was too small. Suddenly he pulls down his pants and asks you if you think it is too small. [Consider the same scenario with a new patient who is concerned about the size of her breasts.]

- What are you feelings?
- What are you thinking?
- What are your fantasies about this scenario?
- What would you, as therapist, want to say first? Why?
- What do you think you would say first? Why?
- What difference would it make if this were a client you had been treating for a year rather than a new client?
- How, if at all, would your feelings and actions be different according to whether treatment was conducted on an inpatient or an outpatient basis?
- How, if at all, would your feelings and actions differ according to the gender of the client or whether the clients' sexual orientation and your own sexuality?
- Imagine that the client in the scenario is 15 years old. What feelings does the scenario evoke in you? What do you do? What fantasies occur to you about what might happen after the event described in the scenario?

• • •

Your client describes to you her troubled marriage. Her husband used to get mad and hit her—"not too hard," she says—but he has pretty much gotten over that. Their sex life is not good. Her husband enjoys anal intercourse, but she finds it frightening and painful. She tells you that she would like to explore her resistance to this form of sexual behavior in her therapy. Her goal is to become comfortable engaging in the behavior so that she can

please her husband, enjoy sex with him, and have a happy marriage.

What are you feeling when the client says that her husband used to “get mad and hit her”?

What are you thinking?

What are you feeling when she says that she finds anal intercourse frightening and painful?

What are you thinking?

What do you feel when she describes her goals in therapy?

What are you thinking?

In what ways do you believe that your feelings may influence how you proceed with this client?

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The therapy group you are leading is into its eighth month of weekly meetings. One of the members of the group begins sobbing, describes terrible feelings of depression, and ends by pleading “I need someone to hold me!”

Bob, another member of the group, spontaneously jumps up and goes over to the other member, who stands up. As they embrace, it becomes obvious that Bob is getting an erection. He continues the hugging, which the other group member seems to find comforting, and seems to be stimulating himself by rubbing up against the other person.

- When you imagine this scenario, what do you feel?
- Would you, as therapist, call attention to what is happening? If so, how?
- If you were the therapist, could you imagine that such an event might make you feel aroused? frightened? upset? angry? confused?
- Do any of the following considerations change the feelings that this scenario evokes in you:

- Whether your supervisor is watching this scene through a one-way mirror
- Whether Bob and the client are the same gender
- Whether Bob is suffering from schizophrenia
- Whether Bob is a pedophile
- Whether the client receiving the hug seems to be aroused
- Whether Bob had been sexually abused during childhood
- Whether this is an inpatient group
- Whether all members of this group are suffering from terminal illnesses
- Whether the client receiving the hug had been sexually abused during childhood
- Whether the client receiving the hug has sued a prior therapist for malpractice in regard to sexual issues

...

You are working in a busy mental health center in which the doors to the consulting rooms, while offering some privacy, are not completely soundproof. As long as therapist and client are talking at a normal level, nothing can be heard from outside the door. But words spoken loudly can be heard and understood in the reception area.

A client, Sal, sits in silence during the first 5 minutes of the session, finally saying “It’s been hard to concentrate today. I keep hearing these sounds, like they’re ringing in my ear, and they’re frightening to me. I want to tell you what they’re like, but I’m afraid to.”

After offering considerable reassurance that describing the sounds would be okay and that you and Sal can work together to try to understand what is causing the sounds, what they mean, and what you might do about them, you notice that Sal seems to be gathering the courage to reveal them to you.

Finally, Sal leans back in the chair and imitates the sounds. They build quickly to a very high pitch and loud volume. They sound exactly like someone becoming more and more sexually aroused and then experiencing an intense orgasm.

You are reasonably certain that these sounds have been heard by the receptionist, some of your colleagues, the patients sitting in the waiting room, and a site visitor from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) who is deciding whether the hospital in which your clinic is based should have its accreditation renewed.

- What feelings does this scenario evoke in you?
- As you imagined the scene, was the client male (Salvador) or female (Sally)? Does the client's gender make any difference in the way you feel?
- If Sal began to make the sounds again, would you make any effort to interrupt or ask the client to be a little quieter? Why?
- If none of the people who might have heard the sounds mentioned this event to you, would you make any effort to explain what had happened?
- Imagine that just as Sal finishes making these sounds, someone knocks loudly on the door and asks, "What's going on in there?" What do you say or do?
- Would your feelings or behavior be any different if the sounds were of a person being beaten rather than having an orgasm?
- How would you describe this session in your chart notes?
- If you were being supervised, would you feel at all apprehensive about discussing this session with your supervisor?
- What approach do you usually take toward your clients' making loud noises that might be heard outside the consulting room?

• • •

Over the past year you have been struggling with feelings of loneliness and isolation, so you decide that it is time to make some changes in your life. You are planning to go out more, make new friends, and date in hopes of finding a partner. As you begin to envision your new life, one of your clients keeps coming to mind. You enjoy talking to them so much that sometimes you fantasize about spending time with them outside of therapy. During the last session with this client, they mentioned that their “favorite time of the week was coming to see you.” This statement makes you so happy that you kept thinking about it all day and it made it very difficult for you to focus on your paperwork. Now you cannot wait to see your client for the next session. For a second, you considered sharing what you are feeling with your colleague (supervisor if you’re not licensed or are in training) with whom you often consult with about cases, but then decided not to do it.

- What is your first reaction to this case scenario?
- How would you respond to your client’s statement?
- What if any risk factors for a slippery slope do you see in this case?
- In what ways, if any, can the current situation impact your client?
- Would you make any changes to your current work with this client? If so what changes and why?

• • •

It’s Monday morning and you have a busy day ahead. You’re responding to e-mails and phone calls before your first session of the day. Your cellphone alerts you that a text has arrived. It’s your 9 am client letting you know that they’re running about 15 minutes late and on their way. You automatically think, “Oh that gives me extra minutes to respond to a few more e-mails.” You pick up your phone and quickly reply with “Thank you for letting me know. See you when you get here.” Right after hitting send your jaw drops as you see that an inappropriate and risqué photo

somehow accompanied your reply text to your client.  
Multitasking fail.

- What feelings does this scenario evoke in you?
- How do you plan to address the incident when your client arrives?
- What are some best actions to take if your client is a no show?
- Would your feelings or behavior be any different if your client is of the same gender as you? What about if they have the same or different sexual orientation than you?

# **Chapter 26**

## **NONSEXUAL MULTIPLE RELATIONSHIPS AND OTHER BOUNDARY CROSSINGS**

### **The Therapeutic, the Harmful, the Risky, and the Inevitable**

Crossing a boundary can be profoundly healing and therapeutic. It can reshape how the patient views the therapist. It can strengthen and deepen the working relationship. It can heal rifts, speed growth, and break through an impasse. It can make a patient feel less alone, less hopeless, more understood, and at times less suicidal.

In some cases, a refusal to cross a boundary is not just lost opportunity, it's harmful. For example, in one of the descriptions over the decades of his own nonsexual boundary crossings with patients and how they turned out, one of this book's authors (Pope) described in the *American Psychologist* in 1995 ("Biography") his daily therapy sessions with a patient that included such boundary crossings as having a friend send \$500 and an open airline ticket to the patient. He believed that not crossing these boundaries would have been harmful to the patient facing these circumstances.

Vasquez (2009) describes how failure to cross boundaries with culturally diverse clients can sometimes risk damaging the basic working alliance, which in turn can lead clients to abandoning therapy (see also Barnett & Jacobson, 2019; Shors & Kroll, 2019).

Like many powerful resources, crossing a boundary involves risks. Done in the wrong situation, at the wrong time, or with the wrong person, it can knock the therapy off track, sabotage the treatment plan, and offend, exploit, or harm the patient.



The question, “Do I cross this particular boundary with this particular patient now?” confronts us every day. Below are some scenarios related to boundary crossing some of us may encounter:

- My client has just told me that his mother died unexpectedly, and he’s asked me to attend the funeral. What should I tell him?
- My favorite musician who never tours in this part of the country has scheduled a one-night-only concert here. It was sold out before I could buy a ticket, but a client has brought me a ticket and backstage pass as a gift. Is there any reason I should turn them down?
- My reading group meets every month to discuss a new novel and how it relates to our lives. On the way to our cars at the end of the meeting, one member asked to make an appointment with me. He wants to begin therapy. It caught me off guard—I didn’t know what to say.
- My client asked me if I believe in God. I’m not sure how I should handle that question. She has been talking about how her synagogue views her sexuality and I believe she will also ask me about my sexual orientation. I wish I knew how to handle personal questions.
- My client has lost his wife and two young children in a fire and has just started sobbing—Should I end the session on time—which is now—or extend it another 5–10–15 minutes? Longer? But I have just enough time to make it to the court to testify as an expert witness.
- Just as I was ending the last session of the day, a thunderstorm erupted. My client usually walks home—it’s about a quarter of a mile. Is there any reason I shouldn’t offer a ride?
- My client will lose their home if they can’t come up with a payment by tomorrow. They start their new job in two weeks. If they have nowhere else to turn, should I lend them the money to tide them over until they start receiving a salary?

In the next sections, we explore a rich array of complex issues including:

- How the Field Changed its View of Boundary Issues
- What Makes This Area So Hard for Us?
- Research Leading to a Call for a Change in the Ethics Code
- Multiple Relationships as Defined by the APA and CPA Ethics Codes
- Three Interesting Examples of Multiple Relationships
- Research Review
- Self-Disclosure
- Bartering
- Multiple Relationships and Boundary Issues in Small Communities
- Seven Common Therapist Errors and Mending Fences
- Sources of Guidance
- Scenarios for Discussion

## **HOW THE FIELD CHANGED ITS VIEW OF BOUNDARY ISSUES**

The way the profession approached questions about boundary issues changed radically in the period that began in 1980 and ran into the mid-1990s. During that period of intense questioning, thoughtful articles, books, and chapters explored and argued about boundaries from virtually every possible point of view. This healthy storm of controversy blew away the dust that had settled over all the old ideas about dual relationships and other boundary issues, and in many cases blew away the ideas themselves. New ideas were argued. New perspectives were tried on for size. Authors explored key factors that had been overlooked. Every suggested standard, guideline, and approach was examined and cross-examined for possible benefits, drawbacks, and unintended consequences.

To illustrate, in 1981 Samuel Roll and Leverett Millen presented “A Guide to Violating an Injunction in Psychotherapy: On Seeing Acquaintances as Patients.” Karen Kitchener’s influential 1988

article, “Dual Role Relationships,” helped us sort out “counselor–client relationships that are likely to lead to harm and those that are not likely to be harmful” (p. 217). Kitchener suggested that dual relationships are more likely to cause problems if they involve “(1) incompatibility of expectations between roles; (2) diverging obligations associated with different roles, which increases the potential for loss of objectivity and divided loyalties; and (3) increased power and prestige between professionals and consumers, which increases the potential for exploitation” (p. 217).

Robert Ryder and Jeri Hepworth (1990) argued thoughtfully that the American Association for Marriage and Family Therapy (AAMFT) should not prohibit dual relationships in its ethics code. Janet Sonne (1994) examined the ways in which the then-current APA ethics code addressed multiple relationships and argued that some segments represented “steps backward” (p. 343). Vincent Rinella and Alvin Gerstein wrote that “the underlying moral and ethical rationale for prohibiting dual relationships (DRs) is no longer tenable” (1994, p. 225). Tom Gutheil and Glen Gabbard (Gutheil & Gabbard, 1993) maintained that “boundary crossings may be benign or harmful” (p. 195) and explored factors that influence the impact.

Elisabeth Horst (2020), Amy Stockman (1990), and Floyd Jennings (1992) helped raise our awareness and appreciation of the special challenges that rural settings present for dual relationships and other boundary issues. Laura Brown was among those who thoughtfully argued against a simple prohibition when considering dual relationships and other boundary issues in the lesbian therapy community in “Beyond Thou Shalt Not: Thinking About Ethics in the Lesbian Therapy Community” (1989; see also Brown, 1994).

Melanie Geyer (1994) proposed adopting some of the special guidelines for considering multiple relationships and other boundary issues in rural settings and adapting them for difficult dilemmas faced by Christian counselors (and counselors for whom other religious faiths are a primary foundation and concern of practice). Bruce Sharkin and Ian Birky (1992) focused attention on the unplanned, unexpected encounters between therapists and clients and on the difficulties of maintaining boundaries during incidental encounters.

Jeanne Adleman and Susan Barrett (1990) were among those who pioneered considering multiple relationships and other boundary issues afresh using feminist principles. Patruska Clarkson's "In Recognition of Dual Relationships" explored the implications of believing in a "mythical, single relationship" and cautioned therapists and counselors against "an unrealistic attempt to avoid all dual relationships" (1994, p. 32). Ellen Bader (1994) maintained that therapists should stop focusing on whether there are dual roles and instead consider whether each instance represents exploitation.

Smith and Fitzpatrick summarized a review of the research that was conducted during the period of re-thinking nonsexual boundaries in the years leading up to 1995:

The effects of crossing commonly recognized boundaries range from significant therapeutic progress to serious, indelible harm .... Although setting appropriate boundaries is a professional imperative, flexibility in their maintenance is equally important. Clinicians should avoid setting simplistic standards that may create barriers to therapeutic progress. In the final analysis, ethical practice is governed less by proscriptions than by sound clinical judgment bearing on the therapeutic interventions that will advance the client's welfare (Smith & Fitzpatrick, 1995, p. 505).

The care with which the work reviewed above, as well as other work from the 1980s to the mid-1990s, called attention to several factors (e.g., setting, culture, expectations, theoretical orientation) that are important to consider when thinking through whether a specific multiple relationship or other boundary crossing with a specific client and in a specific situation may be helpful or harmful. This work has also encouraged clinicians to appreciate the complexity of these decisions and engage in careful questioning about the various options rather than uncritical rule following.

The process of deciding what the best alternative may be for the client also often involves considering the clinician's feelings, as Jeffrey Kottler's frank exploration discloses:

Sorting out dual relationships has become the most prevalent ethical issue of our time .... Our family members and friends constantly ask us for advice. Although we may do our best to beg off, the truth of the matter is that we may well enjoy being needed. I love it when people ask me what to do .... I feel so self-important that someone else thinks I know something that they do not. I pretend I am a little annoyed by those who ask me how to handle their children, confront their bosses, or straighten out their lives, but I appreciate the fact that they thought enough of me to ask (2003, p. 4).

## **WHAT MAKES THIS AREA SO HARD FOR US?**

Sabine Wingenfeld-Hammond (2010) notes that “one of the most challenging ethical issues for professional psychologists involves maintaining and managing professional boundaries” (p. 135). Why is this area so challenging for almost all of us as individuals and as a profession? Below we describe four potential causes that may contribute to this phenomenon.

### **1. Being Caught Unprepared**

First, boundary dilemmas can catch us off-guard and feeling unprepared. They can sweep us into unfamiliar territory and call for quick decisions that can have lasting impacts. [Chapter 22: Recognizing, Assessing, and Responding to Suicidal Risk](#), provides, an example of how a sudden decision to cross a boundary can have a profoundly transformative and healing effect. In this example, Stone (1982) describes a young woman, hospitalized during a psychotic episode, who continuously vilified her therapist for not caring about her. Without warning, she escaped from the hospital:

The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made great progress in treatment. Later, after making substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the “midnight rescue mission” it was clear, even to her, how concerned and sincere her therapist had been from the beginning (p. 271).

Interestingly, since the time that this example and related accounts of the positive and healing potential of boundary crossings appeared in the first edition of this book in 1991, they have been one of the most frequent topics of reader comments.

## **2. Self-Interest vs. The Client’s Needs**

Second, opportunities to cross boundaries can—as Jeffrey Kottler’s courageous statement shows—tap into some of our most basic needs and strongest desires. It is possible to fall vulnerable to fallacies in reasoning and judgment (see [Chapters 10–14](#)) and mistake our own self-interest for our client’s needs. For instance, our own needs and desires may prompt us to see crossing boundaries that we want to cross in the way that we want to cross them as if they were the only and most meaningful clinical intervention, the only humane approach, the only prospect for helping the client. Hence, we convince ourselves that what we want to do is an ethical imperative. Glen Gabbard wrote:

Harry Stack Sullivan (1954) once observed that psychotherapy is a unique profession in that it requires therapists to set aside their own needs in the service of addressing the patient's needs. He further noted that this demand is an extraordinary challenge for most people, and he concluded that few persons are really suited for the psychotherapeutic role. Because the needs of the psychotherapist often get in the way of the therapy, the mental health professions have established guidelines, often referred to as boundaries, that are designed to minimize the opportunity for therapists to use their patients for their own gratification (1994, p. 283).

### **3. The Allure of Rigidity**

Third, the need for clarity about boundaries can be misunderstood as the need for inflexible boundaries reflexively applied. Clearly thinking through boundary issues for each patient is essential. Reflexively applying a rigid set of rules about inflexible boundaries can never be an acceptable substitute for critically thinking through boundary issues for an individual client as clearly and carefully as possible. Decisions about boundaries must reflect strong ethical awareness of: (a) the potential benefits and harm; (b) the patient's needs and well-being; (c) informed consent and informed refusal; (d) the psychotherapist's motives; and (e) their knowledge and competence.

### **4. Emotions and Risk Management**

Fourth, boundary decisions can evoke anxiety and even fear. For example, clinical and forensic psychologist Martin Williams points out that some clinicians may try to avoid the area entirely to minimize the risk of being sued. He describes how the fear of lawsuits and ethics complaints can lead clinicians to avoid even justifiable boundary crossings. He uses the work of one of this book's authors as an example. This example, originally published in the *American Psychologist* ("Biography," 1996), was mentioned at the opening of this chapter. The example involved providing psychological services to a homeless woman who had survived an assault, who was being stalked, and whose life was at risk. Williams

noted how the author's work with the client included instances of what Gutheil and Gabbard (1993) might term boundary crossings (although not boundary violations):

[This] treatment ... included daily meetings without fee and his arranging for a personal friend of his to lend the patient money and to provide her with an airline ticket and a place to stay. In the context of the particular case, these boundary excursions appeared to be both humane and sensible. However, some practitioners might, in the interest of risk management, avoid making similar modifications (1997, p. 248).

## **RESEARCH LEADING TO A CALL FOR A CHANGE IN THE ETHICS CODE**

Chapter 3 noted that the original APA ethics code was empirically derived and based on the result of a survey of the membership, asking them what ethical dilemmas they encountered. It also described a replication of that critical incident study a half-century later. This 1992 replication, published in the *American Psychologist*, found that the second-most often reported ethical dilemmas were in the area of “blurred, dual, or conflictual relationships” (Pope & Vetter, 1992).

On the basis of their findings, Pope and Vetter called for changes to the APA ethical principles in the areas of dual relationships, multiple relationships, and boundary issues so that the ethics code would:

- Define dual relationships more carefully and specify clearly conditions under which they might be therapeutically indicated or acceptable.
- Address clearly and realistically the situations of those who practice in small towns, rural communities, remote locales, and similar contexts (emphasizing that neither the current code in place at the time nor the draft revision under consideration at that time fully acknowledged or adequately addressed such contexts).
- Distinguish between dual relationships and accidental or incidental extra-therapeutic contacts (for example, running into a



patient at the grocery market or unexpectedly seeing a client at a party) and to address realistically the awkward entanglements into which even the most careful therapist can fall (p. 401).

In the following excerpt from that article *Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey*, Pope and Vetter (1992) present those findings and recommendations in detail, including examples provided by the survey participants:

## **BLURRED, DUAL, OR CONFLICTUAL RELATIONSHIPS**

The second-most frequently described incidents involved maintaining clear, reasonable, and therapeutic boundaries around the professional relationship with a client. In some cases, respondents were troubled by such instances as serving as both “therapist and supervisor for hours for [patient/supervisee’s] MFCC [marriage, family, and child counselor] license” or when “an agency hires one of its own clients.” In other cases, respondents found dual relationships to be useful “to provide role modeling, nurturing and a giving quality to therapy”; one respondent, for example, believed that providing therapy to couples with whom he has social relationships and who are members of his small church makes sense because he is “able to see how these people interact in group context.” In still other cases, respondents reported that it was sometimes difficult to know what constitutes a dual relationship or conflict of interest; for example, “I have employees/supervisees who were former clients and wonder if this is a dual relationship.”

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Taken as a whole, the incidents suggest the ethical principles need to define dual relationships more carefully and to note with clarity if and when they are ever therapeutically indicated or acceptable. For example, a statement such as “Minimal or remote relationships are unlikely to violate this standard” (“Draft,” 1991, p. 32) may be too vague and ambiguous. A psychologist’s relationship to a very casual acquaintance whom she or he meets for lunch a few times a year, to an accountant who only does very routine work in filling out her or his tax forms once a year (all such business being conducted by mail), to her or his employer’s husband (who has no involvement in the business and with whom the psychologist never socializes), and to a travel agent (who books perhaps one or two flights a year for the psychologist) may constitute relatively minimal or remote relationships. However, will a formal code’s assurance that minimal or remote relationships are unlikely to violate the standard provide a clear, practical, valid, and useful basis for ethical deliberation to the psychologist who serves as therapist to all four individuals? Research and professional literature focusing on nonsexual dual relationships underscores the importance and implications of

decisions to enter into or refrain from such activities [citations omitted]

Second, the principles must clearly and realistically address the situations of those who practice in small towns, rural communities, and other remote locales. Neither the current code nor the current draft revision explicitly acknowledges and adequately addresses the complexities related to providing services in such geographic contexts. Forty-one of the dual relationship incidents reported in the Pope and Vetter (1992) survey involved such locales. Many respondents implicitly or explicitly complained about how the principles seem to ignore the special conditions inherent in small, self-contained communities. For example,

*I live and maintain a ... private practice in a rural area. I am also a member of a spiritual community based here. There are very few other therapists in the immediate vicinity who work with transformational, holistic, and feminist principles in the context of good clinical training that “conventional” people can also feel confidence in. Clients often come to me because they know me already, because they are not satisfied with the other services available, or because they want to work with someone who understands their spiritual practice and can incorporate its principles and practices into the process of transformation, healing, and change. The stricture against dual relationships helps me to maintain a high degree of sensitivity to the ethics (and potentials for abuse or confusion) of such situations but doesn’t give me any help in working with the actual circumstances of my practice. I hope revised principles will address these concerns!*

Third, the principles need to distinguish between dual relationships and accidental or incidental extra-therapeutic contacts (e.g., running into a patient at the grocery market or unexpectedly seeing a client at a party) and address realistically the awkward entanglements into which even the most careful therapist can fall. For example, a therapist sought to file a formal complaint against some very noisy tenants of a neighboring house.

When he did so, he was surprised to discover “that his patient was the owner-landlord.” As another example, a respondent reported, Six months ago, a patient I had been working with for three years became romantically involved with my best and longest friend. I could write no less than a book on the complications of this fact! I have been getting legal and therapeutic consultations all along and continue to do so. Currently they are living together, and I referred the patient (who was furious that I did this and felt abandoned). I worked with the other psychologist for several months to provide a bridge for the patient. I told my friend soon after I found out that I would have to suspend our contact. I’m currently trying to figure out if we can ever resume our friendship and under what conditions.

The latter example is one of many that demonstrate the extreme lengths to which most psychologists are willing to go to ensure the welfare of their patients. Although it is impossible to anticipate every pattern of multiple relationship or to account for all the vicissitudes and complexities of life, psychologists need and deserve formal principles that provide lucid, useful, and practical guidance as an aid to professional judgment (Pope & Vetter, 1992, p. 400–401).

Since the initial publication of these findings, both the APA and CPA Ethics Codes have developed clearer, more flexible guidance regarding multiple relationships.

## **MULTIPLE RELATIONSHIPS AS DEFINED BY THE APA AND CPA ETHICS CODES**

Janet Sonne (2005) described how concerns about multiple relationships may not be founded on an accurate understanding of multiple relationships or the ethical standards:

You may have heard in workshops or read in books or journals that hugging a client, giving a gift to a client, or meeting a client outside of the office constitutes a multiple relationship and is prohibited by our ethics code or by the standard of care sustained by professional licensing boards.

Not accurate.

You may also have heard or read that telling a client something personal about yourself or unexpectedly encountering a client at a social event are examples of unprofessional multiple relationships.

Again, not accurate.

The inaccuracies, or errors, in our thinking about nonsexual multiple relationships, mire us in confusion and controversy (2005).

It is worth taking a look at the APA and CPA codes to see how they define this concept. The APA Ethics Code defined multiple relationships for the first time in the 2002 revision (American Psychological Association, 2002). According to Standard 3.05a,

A multiple relationship occurs when a psychologist is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has the professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person (p. 1065).

Most commonly, the second role is social, financial, business, or professional. Standard 3.05a noted that *not all* (emphasis added) multiple relationships are problematic and provides guidance as to when to avoid inappropriate multiple relationships:

A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists (p. 1065).

Thus, psychologists avoid dual or multiple roles with clients unless there is no reasonable likelihood that a secondary role would interfere with their objectivity, competence, or effectiveness in therapy.

The July 31, 2020 Draft Revision of the APA Ethics Code does not use the term “multiple relationship.” The section on “Beneficence and Nonmaleficence” includes the statement: “In addressing conflicts, psychologists attempt resolutions that avoid or minimize harm, weighing the well-being, welfare and rights of those with whom they interact.” And the section on “interrelatedness of People, Systems, and the Environment” includes the statement: “Psychologists working with and/or in complex social systems (e.g., groups, organizations, and communities) recognize their multiple, sometimes competing, roles and ethical obligations and address ethical complexities and conflicts that may arise.”

Section III.33 of the CPA (2017a) Ethics Code states, “Avoid dual or multiple relationships (e.g., with primary clients, client examinees, research participants, employees, supervisees, students, trainees) that are not justified by the nature of the activity, by cultural or geographic factors, or where there is a lack of reasonably accessible alternatives.”

Standard III.34 also acknowledges that some multiple relationships are unavoidable and suggests ways to avoid risk of harm:

Manage dual or multiple relationships or any other conflict-of-interest situation entered into in such a way that bias, lack of objectivity, and risk of exploitation or harm are minimized. This might include involving the affected party(ies) in clarification of boundaries and expectations, limiting the duration of the relationship, obtaining ongoing supervision or consultation for the duration of the dual or multiple relationship, or involving a third party in obtaining consent (e.g., approaching a primary client or employee about becoming a research participant).

## **THREE INTERESTING EXAMPLES OF MULTIPLE RELATIONSHIPS**

Vague and generalized terms like “multiple relationships” and “competing roles” can lull many of us into ignoring the diverse and subtle ways that therapists can invite misfortune. The three specific examples provided below may help to strengthen our ethical awareness in this area.

## **1. Opportunity**

Bill just opened his independent practice office and has exactly two patients. One of them, Mr. Lightfoot, is a successful investment analyst who is grateful to Bill for all the benefits he is getting from psychotherapy. The worst of Mr. Lightfoot’s depression is lifting, and he is now focusing on his relationships with those whose financial matters he handles. Bill, who genuinely likes Mr. Lightfoot, finds himself especially attentive when his patient talks about new investment opportunities. Unexpectedly, Mr. Lightfoot says that Bill might make a great deal of money if he invests in a certain project that is now being planned. The more Bill thinks about it, the more this seems like a terrific opportunity. It will help Mr. Lightfoot’s sense of self-esteem because he will be in the position of helping Bill rather than always receiving help from him. It will not cost Mr. Lightfoot anything. Finally, it may allow Bill to survive in independent practice and thus enable him to continue to help others. (Bill’s overhead was greater than expected, the anticipated referrals were not materializing, and he was down to his last ten thousand dollars in savings, which would not last long given his office rent and other expenses). He decides to give his savings to Mr. Lightfoot to invest for him.

## **2. Employee Benefits**

Dr. Ali is a successful psychotherapist who now owns and manages her own mental health clinic. Lately she has noticed that her normally outstanding secretary, Mr. Miller, has been making numerous mistakes, some of them resulting in considerable financial losses for the clinic. Dr. Ali’s customary toleration, encouragement, and nonjudgmental pointing out of the errors have not improved her secretary’s performance. She decides that a serious and frank discussion of the situation is necessary. When she begins talking with

her secretary about the deteriorating performance, Mr. Miller reveals some personal and financial stresses that make it difficult for him to attend to his work. Dr. Ali is aware that her secretary cannot afford therapy and that the chances of hiring a new secretary with anywhere near Mr. Miller's previous level of skills is at best a long shot. Even if a good secretary could be found in what is a competitive job market, there would be a long period of orientation and training during which Dr. Ali anticipates she would continue to lose revenue. She decides that the only course of action that makes sense, that creatively solves all problems, is to take on Mr. Miller as a patient for two or three hours each week until Mr. Miller has a chance to work through his problems. Mr. Miller could continue to work as secretary and would not be charged for the therapy sessions. Dr. Ali would provide them without charge as part of a creative and generous "employee benefit."

### **3. Helping as a Friend**

Rosa, an attorney, is going through one of the worst times in her life. For several weeks, she had been experiencing mild abdominal discomfort and had dismissed it as a muscle strained while jogging or nervousness about the case she was preparing to argue in her first appearance before the state supreme court. The pains become worse, and she manages to drive herself to the emergency room. A medical resident tells her that she has a large lump on her ovary and that she should make an appointment for tests to see if the lump is cancerous. Before she can say anything, he checks his watch and breezes out of the room

Rosa is terrified. The tests are scheduled for two days from now. She has to cope not only with the pain but also with the uncertainty of what the physicians will discover. She goes immediately to the house of her best friend, June, a psychotherapist. June suggests showing Rosa some self-hypnotic and imagery techniques that might help her cope with her pain and anxiety. As June leads her through the exercises, Rosa begins to feel relieved and comforted. However, when she tries to use the techniques by herself, she experiences no effects at all. June agrees to lead her through the hypnotic and imagery exercises two or three times a day until the medical crisis is resolved. During the fourth meeting, spontaneous images that are



quite troubling begin occurring. Rosa starts talking about them and feels they are related to things that happened to her as a small child. She discusses them in detail with June, and by the end of the sixth session, June recognizes that an intense transference has developed. She encourages Rosa to consult another therapist but Rosa refuses, saying that there is no one else she could trust with these matters and that terminating the sessions would make her feel so betrayed and abandoned that she fears she would take her own life.

## RESEARCH REVIEW

There has been considerable research regarding sexual multiple relationships (see [Chapter 25](#)). However, research concerning the prevalence of nonsexual multiple relationships has been rarer. Tallman (1981) conducted perhaps the earliest study on nonsexual multiple relationships. Of the 38 psychotherapists participating, about 33% indicated that they had formed social relationships with at least some of their patients. An intriguing aspect of the findings was that although only half of the participants were male, all of the therapists who developed these social relationships with patients were male. This significant gender difference is remarkably consistent not only in terms of both sexual and nonsexual multiple relationships in psychotherapy but also in terms of multiple relationships involving teaching and supervision.

Borys and Pope (1989) summarized the initial decade or so of research in this area:

First, the significant difference (i.e., a greater proportion of male than of female psychologists) that characterizes sexualized multiple relationships conducted by both therapists and educators (teachers, clinical supervisors, and administrators) also characterizes nonsexual multiple relationships conducted by therapists in the areas of social/financial involvements and multiple professional roles. Male respondents tended to rate social/financial involvements and multiple professional roles as more ethical and reported engaging in these involvements with more clients than did female respondents. Second, the data suggest that male therapists tend to engage in nonsexual multiple relationships more with female clients than with male clients. Third, these trends hold for psychologists, psychiatrists, and clinical social workers. Note that these statistical analyses take into account the fact that most therapists are male and most patients are female (p. 290).

Pope et al. (1987) included several items regarding nonsexual multiple relationships—"accepting services from a client in lieu of fee," "providing therapy to one of your friends," "going into business with a former client"—in their survey of the ethical beliefs and practices of a thousand clinical psychologists (the return rate was 46%). Their findings were consistent with a larger-scale multidisciplinary study focusing on multiple relationships.

This survey of 1,600 psychiatrists, 1,600 psychologists, and 1,600 social workers (with a 49% return rate) examined beliefs and behaviors regarding a range of multiple relationships (Borys & Pope, 1989). The survey's findings included these three points:

1. There was no significant difference among the professions in terms of sexual involvement with clients before or after termination (see [Chapter 25](#)) or in terms of nonsexual multiple professional roles, social involvements, or financial involvements with patients.
2. The percentage of therapists who rated each multiple relationship behavior as ethical under most or all conditions was invariably less than the percentage of therapists viewing it as never ethical or ethical under only some or rare conditions.

3. Psychiatrists tend, as a whole, to view such relationships as less ethical than do psychologists or social workers.

The study found that various beliefs and behaviors in regard to these boundary issues tended to be significantly related to

- Therapist's gender
- Profession (psychiatrist, psychologist, social worker)
- Therapist's age
- Therapist's experience
- Therapist's marital status
- Therapist's region of residence
- Client gender
- Practice setting (such as solo or group private practice and outpatient clinics)
- Practice locale (size of the community)
- Therapist's theoretical orientation

Baer and Murdock (1995) conducted a national survey using a slightly modified version of the *Therapeutic Practices Survey* reported by Borys and Pope (1989). Their findings suggested that:

Therapists judged social and/or financial involvements with their clients as the least ethical of the three classes of non-erotic dual relationships .... That psychologists appear clear about the importance of meeting their own social and financial needs (other than payment for therapy) through people who are not their clients is important and can be viewed as promising (p. 143).

Lamb and Catanzaro (1998) interviewed therapists, supervisors, and instructors in an academic setting and found that clinicians who admitted to engaging in sexual relationships with clients, supervisees, or students also reported being more likely to engage in nonsexual multiple relationships. They also rated nonsexual multiple relationships as less negative than participants who did not engage in

sexual boundary violations. The authors provided helpful guidelines cited later in this chapter.

Lamb et al. (2004) found that:

a new relationship involving social interactions and events appears to be the type of new relationship that psychologists face most often and about which the greatest clarification may be needed, but psychologists need to be aware of other new relationships as well (e.g., new collegial or professional relationships). Discussing new relationships was reported as occurring most frequently with former (as opposed to current) clients, supervisees, or students, particularly former supervisees (p. 252).

These studies of nonsexual multiple relationships in psychotherapy provide some initial empirical data on which to develop an understanding of the phenomenon and provide some intriguing hypotheses. What is striking, however, is the scarcity of such studies. Thus, it is evident that we need critical self-study, including the systematic collection of data, regarding the occurrence and effects of multiple relationships.

## **SELF-DISCLOSURE**

In contrast to multiple relationships, therapist self-disclosure is one of the most extensively researched boundary issues. Jourard's pioneering book, *The Transparent Self*, sparked widespread interest in the topic when it was published in 1964. His subsequent book, *Self Disclosure: Experimental Analysis of the Transparent Self* (1971) fostered diverse studies. In 1978, Weiner's landmark *Therapist Disclosure: The Use of Self in Psychotherapy*, followed by an updated second edition in 1983, reviewed theory, research, and practice in this area. More recent works that review this area include those by Berg et al. (2020), Farber et al. (2019), Solomonov and Barber (2019), and Magaldi and Trub (2018).

A meta-analysis described how self-disclosure “may be beneficial for building rapport, strengthening alliance, and eliciting client disclosure, with similar [counselor self-disclosure] being especially beneficial” (Henretty et al., 2014, p. 191).

Another meta-analysis found that “Therapist self-disclosure was more often helpful in terms of providing support, whereas therapist immediacy was more often helpful in terms of facilitating clients in talking openly about the therapeutic relationship” (C. E. Hill et al., 2018, p. 445).

Gutheil and Brodsky (2008) provided four ideas that therapists can consider when making self-disclosure decisions:

1. Some degree of self-disclosure by a therapist is inevitable, but such disclosures can become boundary violations when they are not made for the benefit of the patient.
2. Different schools of therapy involve different levels of disclosure, which in turn serve the needs of different patients.
3. Self-disclosures of a personal nature that do not have a clinical purpose ... may [not be helpful and may violate boundaries].
4. Decisions about the therapeutic use of self-disclosure need to be made on a case-by-case basis and in the context of the type of therapy offered (p. 128).

## **BARTERING**

Hill (1999) noted that although bartering carried risks, “it is one way of increasing the availability of therapy, respecting class differences, and avoiding the problems associated with using insurance for payment” (p. 81).

APA allows bartering under some conditions and states that “barter is the acceptance of goods, services, or other nonmonetary remuneration from clients/patients in return for psychological services. Psychologists may barter only if (1) it is not clinically contraindicated, and (2) the resulting arrangement is not exploitative” (APA, 2017a; see Standards 3.05, Multiple Relationships, 6.04, Fees and Financial Arrangements, and Sonne, 1994).

Different disciplines have taken different views of boundary issues—for example, a national survey found that psychiatrists viewed a variety of boundary-crossing behaviors as less ethical than did

psychologists or social workers (Borys & Pope, 1989)—and this is true for bartering as well. A national survey of the beliefs and behaviors of psychologists who were therapists found that most participants viewed bartering with a client as either unethical or unethical under most circumstances (Pope et al., 1987; see also Baer & Murdock, 1995). A similar survey of certified counselors, however, found that 63% viewed bartering for a client's goods and 53% viewed bartering for a client's services as ethical (Pope, 1993).

The Canadian Ethics Code (CPA, 2017a) addresses bartering in the section "Avoidance of Conflict of Interest." Section III.28 states that psychologists would

Not exploit any relationship established as a psychologist to further personal, political, or business interests at the expense of the dignity or well-being of their primary clients, contract examinees, research participants, students, trainees, employers, or others. This includes, but is not limited to ... entering into fee arrangements (e.g., bartering) that are clinically or culturally contraindicated ....(p. 29).

A number of therapists oppose bartering. Robert Woody (1998), for example, reviewed several of the ethical and legal issues and wrote that his "foremost conclusion is that bartering is a bad idea and should be avoided" (p. 177). However, for those who choose to barter with a client, Woody suggests using the following guidelines:

1. Unique financial arrangements should be minimized; that is, terms and conditions for any compensation, including the use of bartering, should be as close to established practices as possible and be consonant with the prevailing standards of the profession.
2. The rationale for any compensation decision, including the use of bartering, should be documented in the case records.
3. Discussions about any financial matters should be detailed in writing, giving equal emphasis to what is said by the psychologist and the client.
4. If bartering is used, there should be a preference for goods instead of services; this will minimize (but not eliminate) the possibility of inappropriate personal interactions.

5. The value of the goods (or services) should be verified by an objective source; this may, however, involve additional cost.
6. To guard against any semblance of undue influence, both parties should reach a written agreement for the compensation by bartering.
7. Any new, potentially relevant observations or comments about compensation by bartering should be entered into the client's records, even though a previous agreement exists.
8. The agreement should contain a provision for how valuations were determined and how any subsequent conflicts will be resolved (e.g., a mediator); this may, however, involve additional cost (and a concern about confidentiality), which will have to be accommodated by the psychologist (i.e., the added expense should not elevate the cost to the client beyond the established service fee).
9. If a misunderstanding or disagreement begins to develop, the matter should be dealt with by the designated conflict resolution source (e.g., a mediator), not the psychologist and client; again, recall the issues of added cost and concern for confidentiality stated in the preceding guideline.
10. If monitoring by the individualized treatment plan reveals a possible negative effect potentially attributable to the compensation arrangement, it should be remedied, or appropriate termination of the treatment relationship should occur (p. 177).

## **MULTIPLE RELATIONSHIPS AND BOUNDARY ISSUES IN SMALL COMMUNITIES**

A community's size and nature provide important context that needs to be considered in boundary issues. A varied and helpful literature explores boundary questions for therapists working in closely knit communities. Examples include some lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities (Brown, 1984, 1988, Darby et al., 2020; Dworkin, 1992; N. K. Gartrell, 1992; Greene, 1997a, 1997b; B. G. Greene & Croom, 1999; Kessler & Waehler, 2005;

Shipman & Martin, 2019; A. J. Smith, 1990); some ethnic minority communities (Bemak & Chung, 2019; Comas-Díaz & Greene, 1994; Landrine, 1995; Pack-Brown & Williams, 2003; Ridley et al., 2001; D. W. Sue & Sue, 2003; Vasquez, 2005; Velasquez, Arellano, & McNeill, 2004), some rural communities (Barnett & Yutzenka, 1995; Brownlee, 1996; Campbell & Gordon, 2003; K. K. Faulkner & Faulkner, 1997; Gripton & Valentich, 2004; Harowski et al., 2006; Horst, 2020; Jennings, 1992; Pugh, 2007; Schank & Skovholt, 1997, 2006; Simon & Williams, 1999), and some faith communities (Barnett, 2016; Sanders, 2016; Smith, 2017).

A central theme of this book is that we cannot shift the responsibility to a set of rules, reflexively applied. Instead, we have to consider how every client is unique in some ways, as is every therapist. Each situation is unique in some ways, and situations continue to change. Therefore, nothing can spare us the personal responsibility of making the best effort we can to assess the potential effects of boundary crossings, which tend to occur more often in small communities, and to act in the most ethical, informed, aware, and creative way possible.

The Feminist Therapy Institute's feminist code of ethics (2000) and the APA Multicultural Guidelines (APA, 2017b) encourage advocacy efforts, community involvement, and activism (see also Arredondo et al., 1996; Chavez-Dueñas et al., 2019; Constantine & Sue, 2005; French et al., 2020; Harper & McFadden, 2003; Moodley & Palmer, 2006; Pack-Brown & Williams, 2003; Roysircar et al., 2003; Sue, 1995; Vasquez & Johnson; [Chapters 7](#) and [23](#) in this book). These activities may create overlapping relationships among therapists and clients, which require careful attention to informed consent, privacy and confidentiality issues, power differentials, and potential pitfalls.

Vasquez (2005) described how small communities and other contexts brought awareness that it is often useful to think of boundaries as continuous rather than dichotomous features of our work. In some small communities, for example, therapists encounter clients and clients' families and friends almost any time they set foot outside. Vasquez addresses decision-making in areas like self-disclosure, nonsexual touch (see also the section on nonsexual touch in [Chapter 25](#)), giving and receiving gifts, attending an important



event for a client (for example, a wedding, graduation, or funeral), and others. Culture can be a critical component that needs to be considered when deciding whether to accept a gift. For example, refusing to accept a gift can create a shaming experience for clients from some cultures.

## **SEVEN COMMON THERAPIST ERRORS AND MENDING FENCES**

In the article “A Practical Approach to Boundaries in Psychotherapy: Making Decisions, Bypassing Blunders, and Mending Fences,” Pope and Keith-Spiegel (2008) discussed common cognitive errors made when making boundary decisions. The errors fall into the following seven categories:

Error #1: What happens outside the psychotherapy session has nothing to do with the therapy.

Error #2: Crossing a boundary with a therapy client has the same meaning as doing the same thing with someone who is not a client.

Error #3: Our understanding of a boundary crossing is also the client’s understanding of the boundary crossing.

Error #4: A boundary crossing that is therapeutic for one client will also be therapeutic for another client.

Error #5: A boundary crossing is a static, isolated event.

Error #6: If we ourselves don’t see any self-interest, problems, conflicts of interest, unintended consequences, major risks, or potential downsides to crossing a particular boundary, then there aren’t any.

Error #7: Self-disclosure is, per se, always therapeutic because it shows authenticity, transparency, and trust.

Pope and Keith-Spiegel (2008) also suggest 9 actions that may be helpful when boundary crossings cause or seem headed toward serious problems.

## **SOURCES OF GUIDANCE**

Although [Chapter 8](#) provides useful actions in thinking through ethical issues and making ethical decisions, there are decision-making guides that focus specifically on multiple relationships. Here are seven decision-making guides that readers may find helpful when considering multiple relationships and other boundary issues:

- Gottlieb's *Avoiding Exploitive Dual Relationships: A Decision-Making Model* (1993, available at <http://kspope.com/dual/index.php>).
- Faulkner and Faulkner's guide for practice in rural settings: *Managing Multiple Relationships in Rural Communities: Neutrality and Boundary Violations* (Faulkner & Faulkner, 1997).
- Lamb and Catanzaro's model in "*Sexual and Nonsexual Boundary Violations Involving Psychologists, Clients, Supervisees, and Students: Implications for Professional Practice* (Lamb & Catanzaro, 1998).
- Younggren's model in *Ethical Decision-Making and Dual Relationships* (2002, available at <http://kspope.com/dual/index.php>).
- Campbell and Gordon's five-part approach for considering multiple relationships in rural communities: *Acknowledging the Inevitable: Understanding Multiple Relationships in Rural Practice* (Campbell & Gordon, 2003).
- Sonne's *Nonsexual Multiple Relationships: A Practical Decision-Making Model for Clinicians* (2005, available at <http://kspope.com>).
- Pope and Keith-Spiegel's *A Practical Approach to Boundaries in Psychotherapy: Making Decisions, Bypassing Blunders, and Mending Fences* (2008, available at <http://kspope.com>).

In addition, Pope, Sonne, and Greene (2006) provide a decision-making model for when we are stuck and have no idea what to do. It was created for those times when “our best understanding of the situation may suggest a course of action that seems productive yet questionable and potentially harmful. To refrain from a contemplated action may shut the door to our spontaneity, creativity, intuition, and ability to help; to refrain may stunt the patient’s progress or impede recovery. To engage in the contemplated action, however, may lead to disaster” (location 2137–2142). They suggest eight actions that can help therapists and counselors find their ways through such impasses.

For internship settings, Burian and Slimp provide a thoughtful approach to making decisions in *Social Dual-Role Relationships During Internship: A Decision-Making Model* (2000; see also Slimp & Burian, 1994).

# SCENARIOS FOR DISCUSSION

You decide to teach a course in basic psychopathology as part of the local community college's associate of arts degree program. You show up on the first day of class and see that there are ten students who have signed up. Two of them are current psychotherapy clients in your practice.

- How do you feel?
- Does their presence change how you teach your first-class session?
- What options do you have for addressing this issue?
- What do you think you would do?
- How, if at all, would you address this issue in the chart notes for these two clients?

...

You live in a very small community. You are the only psychotherapist providing services through an employee assistance program. One day one of your closest friends, someone you have known for several decades, shows up on Zoom, seeking therapy.

- How do you feel?
- Do you share any of your feelings or concerns with the client during this session? If so, what do you say?
- Assume that you do not believe that you can serve as therapist in the light of your close friendship with this person. However, the client points out that not only are you the only one designated to provide therapy under the managed care plan, but that since you are also virtually the only one anywhere near this small community who matches the client in terms of characteristics that the client feels are important (this person believes that only someone who matches the patient's gender, race, and sexual orientation will understand

the issues and be able to help), the client cannot really get help from anyone but you. How do you address this? What are your options? What actions would you take?

• • •

You have been suffering some financial losses and are close to bankruptcy. You will likely lose everything if you are unable to sell your house. You have been trying to sell your house for close to two years and have not received a serious offer. You hold yet another open house. The only person to show up is one of your psychotherapy clients/patients who says, “This is a great house! I’d love to buy it. And although I’d be buying it anyway, it’s nice that it’ll end up helping you”.

- How do you feel?
- What do you think you would say?
- What options do you consider?
- What do you think you’d end up doing?

• • •

A couple, who are your close friends, are aware that you will likely be spending Thanksgiving alone. They invite you to share Thanksgiving day with them, preparing the meal during the morning, feasting at lunch, going for a leisurely walk in the woods during the afternoon, then returning for a light dinner. You show up to discover that they have, without letting you know, invited another unattached person who is presumably your blind date for the day. That person is currently a client/patient to whom you have been providing psychotherapy for two years.

- How do you feel?
- What are your options?
- What do you think you would do?
- How, if at all, would your feelings, options, or probable course change if the person was a former client?

- What if the other guest were your therapy supervisor rather than your client?
- What if the other guest were your own therapist?

• • •

During a session, a patient mentions that because of her job, she receives many free tickets to concerts, plays, and other events. She loves giving them to her various doctors because she greatly appreciates their hard work and because it costs her nothing. She tells you that the day before, she mailed you a pair of tickets to an upcoming concert because you had happened to mention that you are a fan of the performer, who has never held a concert in your part of the country before. You have tried to find tickets to take your daughter, who very much wants to attend, but tickets were immediately sold out and no source seems to have them available at any price.

- What do you feel?
- What issues do you consider?
- Is there any more information that you would want before deciding what to do? If so, what information would you seek?
- Under what conditions, if any, would you accept the tickets?
- After the session is over, how, if at all, would you describe this situation in your chart notes?

You are very involved in your community, and you have been appointed to a new board that is engaged in the kind of activism that you value. When you attend your first board meeting, you discover that one of your new clients is also on the board. Your client comes over at a break to tell you how pleased she is that you share similar values and will be working together.

- How do you feel?
- What feelings do you imagine that your client might be experiencing?
- What issues do you consider?

- What do you think you would say to your client?
- Would you remain on the board? What reasoning leads you to this decision?
- How, if at all, would you chart this interaction?

# Chapter 27

## STEPS TO STRENGTHEN ETHICS IN ORGANIZATIONS

### Research Findings, Ethics Placebos, and What Works<sup>1</sup>

Our work brings us into contact with a remarkable array of organizations. We may work for clinics or hospitals, collect fees from insurance companies or managed care organizations, join professional associations, provide forensic services at prisons, or provide employee assistance program (EAP) services to large corporations. Throughout this book we've highlighted the ethical issues that can arrive in organizational settings, and in [Chapter 9: Moral Distress and Moral Courage](#), we focused on the intense ethical challenges that arise when organizations and other forces violate our professional or personal ethical values. In this chapter we provide suggestions for steps that can strengthen ethics in organizations.

We live in an age that is rich with opportunities to make organizational ethics stronger. Over the past decade striking betrayals of ethics and trust have grabbed the headlines:

- In late February 2020, *U.S. News* headlined news of “USC [University of Southern California] and the Education Department’s Largest Sexual Violence Investigation Ever; Federal officials found that the university failed to investigate allegations of sexual misconduct or do anything to prevent future occurrences” (Camera, 2020). The Associated Press (2020) quoted the head of the Department of Education: “This total and complete failure to protect students is heartbreaking and inexcusable” (para. 2). A doctor who had been employed by USC



for almost three decades, and had been subject to a number of allegations of sexual misconduct over a decade and a half, later became the focus of the largest sex abuse investigation ever undertaken by the Los Angeles Police Department. USC finally agreed to a \$215 million settlement for a class action suit involving tens of thousands of women treated by the doctor (Camera, 2020).

- In 2014, General Motors (GM) admitted that since 2001 it had hidden a potentially fatal design defect. GM engineers, investigators, and lawyers knew, but the company decided that recalling cars would cost too much. Instead, they kept the flaw secret for more than a decade. They kept selling risky cars while the deaths and injuries piled up (Bennett, 2014a, 2014b, 2014c; *Consumer Reports*, 2014; Ivory & Abrams, 2014; Plungis & Higgins, 2014; Viscusi, 2015; A. Young, 2014).
- Famous for its football program's integrity, Penn State covered up child abuse by a football coach for years, allowing the abuser to continue committing crimes. The university-commissioned report stressed "the total and consistent disregard by the most senior leaders at Penn State for the safety and welfare of Sandusky's child victims" (Freeh & Sullivan, 2012, p. 14). Penn State eventually paid \$109 million to Sandusky's survivors (Jesse, 2020).
- California had repealed its "compulsory sterilization laws [that] targeted minorities, the poor, the disabled, the mentally ill and criminals" (Johnson, 2014, para. 8) that allowed the state to force sterilization on more than 20,000 citizens in state-run institutions (Stern, 2005; Wellerstein, 2011), but the California State Auditor (2014) reported that between 2005 and 2013 the state prison system had continued to sterilize some female prisoners, violating both the law and women's right to informed consent. More recently, a whistleblower filed a complaint reporting an alleged high rate of unconsensual hysterectomies being performed on undocumented immigrant women in an immigration detention center in Georgia (Treisman, 2020).
- Many Veterans Administration (VA) executives pocketed hefty bonuses for making sure that sick veterans got prompt care, but

it was a con. Hospitals reported that they were giving all veterans prompt care when needed but were shunting tens of thousands of veterans to secret waiting lists where they languished without care for months and some died without care (Bronstein & Griffin, 2014; Daly & Tang, 2014; Hoyer & Zoroya, 2014; VA Office of the Inspector General, 2014; Oppel & Shear, 2014; Wagner, 2014a, 2014b).

Similarly, studies over the past decade suggest that many organizations have lost the public's trust and confidence, often by violating basic ethical standards and betraying that trust:

- A survey of 10,455 Millennials in 36 countries found a downward trend in confidence that businesses act ethically, with less than half endorsing the belief that businesses act ethically (Verschoor, 2018).
- Huberts (2014) noted that almost half of U.S. workers reported seeing one or more acts of wrongdoing (e.g., accepting kickbacks or bribes, offering bribes to public officials, lying to outside stakeholders, environmental violations) on the job within the past year.
- According to B. Stevens (2013), "Confidence in the ethics of the U.S. business executive remains fairly low on the Gallup Poll surveys and the U.S. has declined on the CPI (Consumer Price Index) and Edelman Trust Barometer" (p. 361).
- In the introduction to a special issue of the *Journal of Law, Medicine & Ethics*, Rodwin (2013) wrote that "today, the goals of pharmaceutical policy and medical practice are often undermined due to institutional corruption—that is, widespread or systemic practices, usually legal, that undermine an institution's objectives or integrity" (p. 544). Elliott (2014) noted that in 2010 the pharmaceutical industry eclipsed the defense industry as the biggest defrauder of the U.S. government.
- A study found that campus judicial systems tend to give light sentences (e.g., writing an essay) for serious violations such as sexual assaults, physical attacks causing serious injuries, robberies, and other violent felonies, leaving many students

reporting that “the system is unfair” and that the campus “has betrayed them” (Binkley et al., 2014).

- Twenge et al. (2014) reported that “confidence in institutions ... reached historic lows among Americans” (p. 1920). They emphasized that the loss of trust and confidence extends across a wide array of institutions: “The trend is not limited to distrust in government; the declines also appear in Americans’ confidence in institutions unconnected to the government, such as medicine, religion, the news media, and TV” (p. 1921).
- As of 2020, the loss of confidence reported by Twenge and her colleagues remains low. According to Gallup (2020), fewer than 50% express either a “great deal” or “quite a lot” of confidence in any of the following institutions: big business (19%), banks (38%), organized religion (42%), the criminal justice system (24%), the Supreme Court (40%), Congress (13%), the police (43%), newspapers (24%), or large technology companies (32%).

This chapter suggests three key steps to strengthen ethics in organizations.

## **STEP 1: KEEP CODES IN CONTEXT**

Organizations often point with pride to their ethics codes, highlighting high ideals and clear prohibitions of questionable conduct. Codes can communicate basic standards and admirable aspirations. For discussion of the ethics codes of the American Psychological Association, Canadian Psychological Association, American Indians, and feminist therapists, see [Chapter 3](#). But ethics codes—including those backed by good-faith enforcement—often fall short of fostering an ethically strong organization. Unethical acts may go unnoticed, noticed acts may go unreported, reported acts may not be fully and fairly investigated, and investigation findings may not be adequately acted on.

Codes that are out of context can create the illusion of ethical behavior, as illustrated by Enron’s famous 84-page organizational code. For instance, Enron required every employee to read and sign the code, which was widely praised for years as a model for other

groups wishing to achieve Enron's reputation for integrity, innovation, and profitability. Years later, Enron's code of ethics shifted from fame to notoriety as prosecutors used it to cross-examine employees in trials that convicted 21 felons after the company collapsed into bankruptcy and caused investors to lose \$74 billion, with losses due to fraud of up to \$45 billion (Arbogast, 2013; Axtman, 2005; McLean & Elkind, 2013; Pasha, 2006; Tang et al., 2018; Watkins, 2013). Additionally, Lease (2006) concluded that "the literature supports ... the contention that an ethical organizational culture cannot be created through the imposition of a code" (p. 29); however, a code can play a key role if those at the top provide ethical leadership by modeling ethical behavior and creating a culture of commitment to ethics throughout the organization.

Kish-Gephart et al.'s (2010) meta-analysis found that the "mere existence of a code of conduct has no detectable impact on unethical choices, despite the considerable amount of statistical power that comes from doing a meta-analytic summary" (p. 21). However, the study also found "a strong, negative link ... between code enforcement and unethical choice" (p. 13).

Weaver (2014) noted that while "empirical research has been clear" that organizational codes per se have "limited, if any, influence on ethical behavior" (p. 293) they must be part of an organization climate in which ethical issues are discussed on an everyday basis and become an ordinary aspect of decision-making and behavior (see also Nicholson, 2008; Weiss, 2014). In turn, the organization's ethical culture becomes internalized as part of each individual's personal values (C. W. Hill et al., 2014).

Green (2020) cited an experimental study finding that a code of ethics did not affect the behavior of software engineers, and noted that this finding "mirrors studies that have similarly shown the limits of ethics codes to affect behavior in other domains" (p. 5).

These and other studies suggest that many ethics codes may be little more than an ethics placebo. Codes work to prompt ethical thinking and action when rooted in an ecology of strong ethical leadership, effective enforcement, and a culture of ethical concern. Ethics questions can rise for everyone to the level of daily concern often devoted to questions of profits, promotions, and will this meeting

ever end? To make ethics stronger in any organization, a reasonable first step is surveying all employees, members, and other stakeholders about current leadership, enforcement, and culture. Moreover, asking every member of an organization about what change is needed while welcoming, encouraging, and modeling open discussions about organizational change can also be fruitful.

## **STEP 2: RESPECT THE TRUE COSTS OF BETRAYING ETHICS**

When it comes to ethics, none of us is perfect. We all fall short, miss red flags, face risky moments of weakness and temptation. How do we mask, reinterpret, or justify our unethical acts to ourselves and, when needed, to others? Each of us likely has our own set of go-to strategies when we find it hard to pass up temptation. [Chapters 10–14](#) discuss ways to strengthen our ethical awareness and critical thinking so that we can identify and avoid some of the most common means (e.g., logical fallacies, flawed judgments, tricks of language, and cognitive strategies of justification) of spinning ethically questionable or objectionable options into seemingly acceptable choices.

These ethical spins deny or downplay the true costs of our unethical acts. The costs of betraying ethics range from seemingly minor wrongs to people dying, as in the GM example. In betraying ethics, GM betrayed its customers, who trusted and relied on the company's honesty, integrity, and good faith. As a result, some GM customers died. Others suffered needless catastrophic injuries. Families suddenly lost a mother, a father, a child, or another loved one. These are the true costs of deciding that fixing a design flaw is “not worth the cost” (Viscusi, 2015, p. 7).

Research supports the idea that betrayal per se can cause harm and may deepen the response to other bad acts. Rachman (2010) noted that betrayal's effects may include “shock, loss and grief, morbid pre-occupation, damaged self-esteem, self-doubting, anger” and sometimes “life-altering changes” (p. 304). Koehler and Gershoff's (2003) set of experiments “found that people reacted more strongly

... to acts of betrayal than to identical bad acts that do not violate a duty or promise to protect” (p. 244; see also Beamish, 2001).

Research also supports the idea that when betrayal happens within organizational dynamics, it may cause institutional betrayal trauma (Brown, 2020; Cromer et al., 2018; Freyd et al., 2005; Gómez, 2020; Hopper, 2020; C. P. Smith & Freyd, 2014). Organizations often betray customers, students, parishioners, prisoners, and others who are not employees, but organizations can also betray their own employees. Kirschman et al. (2013), for example, described organizational betrayal that many police officers experience. They wrote that when this betrayal occurs, it “complicates traumatic reactions by creating huge doubts about the future” (p. 73) and “makes everything else worse” (p. 57). Surís et al. (2007, p. 179; see also Monteith et al., 2019; Surís et al., 2004) found that when soldiers were sexually assaulted within the context of the military organization (i.e., by officers or other military personnel), there were “additional negative consequences above and beyond the effects of [civilian sexual assault].” Ethically strong organizations work to avoid the logical fallacies, judgment errors, tricks of language, cognitive glitches, and pseudoscience—discussed in [Chapters 10](#) through [14](#)—that hide betrayals and their true costs.

To appreciate the ability of such a common event as betrayal to stay out of sight, it may be helpful to remember that psychology itself was slow to recognize it as a topic of study. The PsycNET database includes millions of articles in psychology journals dating back to 1900, but a study—or article of any kind—with the term *betrayal* in the title did not appear in a psychology journal until a single article was published during the 1960s, followed by an average of less than one each year for the next two decades. It was not until 1992, when a special double issue (Volume 8, Issues 3–4) of *Psychotherapy Patient* published seven articles focusing on betrayal, and 1994, when Freyd published “Betrayal Trauma: Traumatic Amnesia as an Adaptive Response to Childhood Abuse,” which was followed by *Betrayal Trauma: The Logic of Forgetting Childhood Abuse* in 1996, that a significant body of published research, theory, and thoughtful discussions began to appear.

The anonymous survey and open discussion recommended previously might include the following questions:

- How has the organization betrayed—or seemed at risk for betraying— ethical standards or aspirations, the organization’s employees or members, and others affected by the organization’s behavior?
- How has the organization denied or downplayed betrayals and their consequences?
- How has the organization failed to assume responsibility for its betrayals?
- What changes would be helpful, and who has the power within the organization to make them?

### **STEP 3: ENCOURAGE SPEAKING UP, LISTENING CAREFULLY, AND ACTING WITH FAIRNESS**

Prior sections suggest an anonymous survey as a starting point. Why? Because organizational culture often silences concerns that the organization’s leadership, culture, code enforcement, or behavior are questionable, somewhat flawed, or worse. Kish-Gephart et al. (2009) wrote, “In every organization, individual members have the potential to speak up about important issues, but a growing body of research suggests that they often remain silent instead, out of fear of negative personal and professional consequences” (p. 163; see also Mayer, Milliken et al., 2003). Similarly, Detert and Treviño (2010) noted that many employees believe from the time they set foot in the door that part of their organizational role is to “‘tread lightly’ around those in power” (p. 264).

Sometimes the belief that speaking up achieves nothing compels those concerned to keep their mouths shut. In some organizations, people in power turn a deaf ear to unwelcome questions, concerns, or reports (for more see Peirce et al., 1998; Pinder & Harlos, 2001). Stakeholders may also lack confidence that ethics concerns or complaints will be met with fairness and justice (Cropanzana et al., 2007; Dunford et al., 2014; Qin et al., 2015). If members of any organization believe that there is one system of ethical accountability

and discipline for those with power, status, and connections and a different system for everyone else, it may create a climate in which the privileged can act with impunity and others learn that voicing ethical questions or concerns about those at the top will at best come to nothing. In any organization, it is worth evaluating how many, if any, of the leaders have publicly acknowledged their own or the organization's ethical missteps. If there have been zero instances in the history of the organization, perhaps the organization has always acted in an ethically perfect manner, the result of those who provide ethically perfect leadership. But perhaps not. One aspect of organizational climate is the degree to which the organization is open to discussing such questions, issues, and concerns.

Research suggests that those who choose to act as whistleblowers must overcome concerns that they will face retaliation or that the risks they take will be in vain (Mayer et al., 2013; Mesmer-Magnus & Viswesvaran, 2005; Miceli et al., 2013). These concerns are often well placed. For example, Dyer (2014) reported that "more than half the whistleblowers who contacted the UK charity Public Concern at Work for advice in 2012 were sacked or resigned after raising concerns about wrongdoing, risk, or malpractice" (p. 6285). An additional 22% were disciplined or punished in other ways. Only 6% reported that their speaking up led to improvements in the workplace.

Rothschild and Miethe (1999) found that whistleblowers tend to "suffer severe retaliation from management, especially when their information proves significant" (p. 107). McDonald and Ahern (2000) found that nurse whistleblowers tended to suffer severe consequences, whereas those who kept silent experienced few negative effects. The official reprisals included demotion (4%), reprimand (11%), and referral to a psychiatrist (9%). Whistleblowers also reported that they received professional reprisals in the form of threats (16%), rejection by peers (14%), pressure to resign (7%), and being treated as a traitor (14%). Ten percent reported that they felt their career had been halted (McDonald & Ahern, 2000, p. 313).

In reviewing actual cases of whistleblowing in organizations, Asaoka (2020) found that firms not only "harbor misconduct and cover it up, but also that they are willing to fight back against whistleblowers,



even when these are top managers or company veterans. Fears of retaliation are real ..." (p. 4).

A former employee of Enron, Sherron Watkins (2013), described how blowing the whistle on questionable activities derailed her career. For instance, while she received positive media coverage of her insider disclosures of Enron's wrongdoing and testimony as a key prosecution witness in the criminal and civil trials, her career was impacted. Despite being named *Time's* "Person of the Year" where she shared the cover with two other whistleblowers from other organizations the corporate world took a dimmer view. A decade later she wrote that "the label Enron whistleblower means I will not work in Corporate America again" (p. ix).

Jackall (1988) gathered the rules of organizational silence into a series of five warnings:

(1) You never go around your boss. (2) You tell your boss what he wants to hear, even when your boss claims that he wants dissenting views. (3) If your boss wants something dropped, you drop it. (4) You are sensitive to your boss's wishes so that you anticipate what he wants; you don't force him, in other words, to act as boss. (5) Your job is not to report something that your boss does not want reported, but rather to cover it up. You do what your job requires, and you keep your mouth shut (p. 115).

A culture of silence and silencing can close off many routes to better organizational ethics. An anonymous survey might begin by asking the following: If you were to raise concerns about ethics or blow the whistle on unethical behavior, how do you think your colleagues and those higher up in the organization would respond? What would happen to your concerns, and what would happen to you? But if the organization's culture lacks trust, those asked to fill out the survey may wonder: Will they recognize my identity in some way? Are the forms coded? If I go to all the trouble of filling it out, will anyone even read it? Take it seriously? Treat it fairly? Use it to make things better?

In some cases, it may make more sense to simply start looking for ways to change the culture and dynamics of silencing. What immediate steps would encourage and support speaking up and

show that valid criticism is heard, valued, and acted on with fairness and justice? Can the costs of speaking up be eliminated or at least minimized?

## **CONCLUSION: ONLY IF WE ACT**

Any steps to make organizational ethics stronger can succeed only if we actually take the steps. Taking action requires us to leave our role as passive bystanders (aka enablers) when we learn of questionable or unacceptable behavior, especially when the welfare of others is at stake.

We must often teach ourselves how to leave the comfort and safety of “it’s not my problem,” “I don’t get paid enough to deal with this,” “someone else will take care of this,” “it’s probably not as bad as it looks,” or “speaking up won’t make any difference.” However, formal programs show promise in teaching and encouraging bystanders to take action in a range of situations such as theft, sexual harassment, interpersonal or systemic racism, bullying, or sexual assault (Brüggemann et al., 2019; Dal Cason et al., 2020; Guerette et al., 2013; Kleinsasser et al., 2015; Nelson et al., 2011; Nickerson et al., 2014; Palm Reed et al., 2015; Salmivalli, 2014; Van Bommel et al., 2014; Wonderling, 2013).

Moral courage (see [Chapter 9](#): Moral Distress and Moral Courage) can strengthen organizational ethics. Serrat (2010) described that “At its most basic, moral courage helps cultivate mindful organizational environments that, among others, off-set groupthink; mitigate hypocrisy and ‘nod-and-wink’ cultures; educate mechanical conformity and compliance; bridge organizational silos; and check irregularities, misconduct, injustice, and corruption” (p. 2; see also Hannah et al., 2011; Osswald et al., 2010; Simola, 2015). It often takes moral courage to take action—whether action means using a survey to find out what changes might make organizational ethics stronger, trying to help bring about those changes, or blowing the whistle inside or outside the organization.

Finally, even if we are concerned about, committed to, and focused on taking steps to prevent questionable or objectionable practices on an individual and organizational level, our lives may be so textured

with tight schedules, heavy responsibilities, and constant distractions that we miss chances to act. Darley and Batson (1973) conducted an experiment showing how a lack of attention to our immediate surroundings—the here and now—can lead to missed opportunities. Princeton Theological Seminary students participated in an experiment in which they were given time to prepare a brief talk in one locale and then had to give the talk in another building. As the students walked through an alley between the buildings, each found someone pretending to be a victim in need of help— slumped over in a doorway, eyes shut, head down, unmoving. The victim coughed and groaned. Half of the students prepared a talk on the parable of the Good Samaritan, and yet many did not stop to help the victim. Those who were about to talk about the importance of acting like the Good Samaritan were no more likely to stop to help than those who were assigned to talk about another topic. To save time, some stepped over the victim rather than going around.

As we go about taking steps to make ethics stronger in organizations, this study reminds us that chances to make a difference often come at an inconvenient time and catch us off guard, appearing in forms we did not expect, that we can pass by it without noticing, and that we need to pay attention to what shows up unannounced at every step.

## Notes

- <sup>1</sup> This chapter is adapted from and used with permission from the article: Pope, K. S. (2015). Steps to strengthen ethics in organizations: Research findings, ethics placebos, and what works. *Journal of Trauma & Dissociation*, 16(2), 139–152. ©Taylor & Francis.

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# ABOUT THE AUTHORS

## KENNETH S. POPE, PHD, ABPP

Ken Pope is a licensed psychologist. A Fellow of the Association for Psychological Science (APS), he served as chair of the Ethics Committees of the American Board of Professional Psychology and the American Psychological Association (APA). He received the APA Award for Distinguished Contributions to Public Service, the APA Division 12 Award for Distinguished Professional Contributions to Clinical Psychology, the Canadian Psychological Association's John C. Service Member of the Year Award, and the Ontario Psychological Association's Barbara Wand Award for significant contribution to excellence in professional ethics and standards.

Well, that's the formalistic version, written in the traditional but bizarre third person, as if someone else were writing it. Here's what really happened.

Going to hear Dr. Martin Luther King, Jr., and the community organizer Saul Alinsky changed my life forever. Who they were and what they said grabbed ahold of me, wouldn't let go.

By the time I graduated from college, their words had convinced me to delay a fellowship to study literature so that I could learn community organizing and try to make a difference. I worked in an inner-city area of severe poverty during the late 1960s and early 1970s. For the first time in my life, I lived where there were no neighbors of my own race.

Those years showed me how poverty, unmet basic needs, and injustice can assault individual lives. I also witnessed the power of people working together to bring about profound change.

A crucial lesson began one day in a cafe where the community gathered. A deacon in a church whose roots reached back to the days before the Civil War invited me to visit the church that Sunday.

I entered the church that weekend and found a seat at the back, looking forward to the minister's sermon. When the time came for the sermon, the minister walked up to the pulpit, looked out at us, and began, "We are most pleased that our neighbor, Mr. Ken Pope, agreed to visit us today, and we look forward to his sermon." This taught me not to assume that my understandings are always shared by others—and that life often calls us to do more than just show up.

After my years living in that community, I began the delayed fellowship to study literature at Harvard. But the years between college and graduate school had changed me. When I received an MA at the end of the year, I did not want to continue studies in that field. I explained my change of heart, expecting to be shown the door. But they surprised me. They told me I could continue to study, taking whatever courses I found interesting in any fields. Some courses I took the next year were in psychology and they felt like my home. I'll always be thankful to the university for their kindness in allowing me to delay my fellowship, in letting me take courses in diverse fields, and in the professors' generosity with their time and support. Because Harvard lacked a clinical psychology program, I transferred to Yale for my clinical psychology doctorate.

What happened in these early years has kept happening throughout my life: Fellow students, colleagues, patients, and others have made me realize that whatever beliefs I held at any given time could be—and often needed to be—rethought, that I needed to consider new perspectives, new possibilities, new ways of finding, creating, and using resources.

One example: Our faculty-intern discussions followed a predictable pattern. Asked to present a case, each of us interns would choose to describe that week's version of "my toughest case," making clear what tough challenges we faced and how brilliant our insights and interventions. Midyear, an intern broke the pattern: "I feel awful this week. The situation was not that difficult but I made some bad mistakes, and ended up having to hospitalize the patient. I need help figuring out what's going on with this patient, why I did what I did, and how I can do things differently." Her honesty, courage, integrity, and clear concern for the person she wanted to help shook us awake from our complacent habits of thinking and feeling. We confronted

how we approached learning and how we treated each other. We talked about how fear, envy, and competitiveness affected who we were, how we thought, what we did. One person had changed our community.

In my early years as a licensed psychologist, I served as clinical director of a nonprofit hospital and community mental health center. My prior experiences led me to focus on the ability of the staff, the Board of Directors, and the surrounding community to work together identifying needs and creating ways to meet those needs. Working together, the diverse individuals in that array of groups created home-bound psychological services, a 24-hour crisis service, legal services for people who are poor or homeless, a program for people whose primary language is Spanish, and group homes allowing people who are mentally disabled to live independently.

What the people in those groups accomplished showed again and again the decisive role that each can play in the lives of others, the ways we can awaken each other to new perspectives and possibilities, and how people working together can bring about change.

Teaching the occasional undergraduate course at the University of California, Los Angeles (UCLA) psychology department, supervising therapy in the UCLA Psychology Clinic, chairing the ethics committees of the American Psychological Association (APA) and the American Board of Professional Psychology (ABPP), becoming a charter member and later Fellow of what is now the Association of Psychological Science (APS), and other experiences in those early years kept reminding me of the need to keep rethinking what I think I know and my ways of working, to ask “What if I’m wrong about this?,” “Is there a better way to understand this?,” “What else could I do that might be more effective?”

Since leaving institutional work in the mid-1980s, I’ve been an independent clinical and forensic psychologist, but the themes of my work, touched on above, continue, even as they continue to take on new forms.

One question I’ve struggled with is: How can psychologists have better access to relevant information without it adding to their time restraints and financial burden?

Twenty-five years ago, I started a Psychology News List via email, free and open to all. I wanted to make it a little easier—especially for those in isolated areas or those who lack easy access to the relevant materials—to keep up with the new research, changing legal standards, controversial topics, and other trends that affect our work. Each day I send out 6 to 10 items, most of them excerpts from new and in-press articles from psychology and other scientific and professional journals, psychology-related articles from that day's newspapers, new court decisions affecting psychology, job announcements, and referral requests sent to me by list members. Although not a discussion list and now quite large, it has become a supportive community. From time to time members ask me to circulate a request for information or suggestions for dealing with an aging parent, a family emergency, a clinical or forensic issue, or a business-related problem with their practice—almost all write to me later to tell me how supported they felt to receive so many personal responses.

Another way we can make information more accessible is through websites that provide articles and other resources without making access contingent on subscriptions, memberships, fees, or other restrictions. Two of mine are “Articles, Research, & Resources in Psychology” at <http://kspope.com> and “Accessibility & Disability Information & Resources in Psychology Training & Practice” at <http://kpope.com>.

For 29 years APA was my professional home. As chair of the APA Ethics Committee and a Fellow of 9 APA Divisions, I worked with many people who became close friends and gave so much to my professional and personal life. I was honored to receive the APA Award for Distinguished Contributions to Public Service “for rigorous empirical research, landmark articles and books, courageous leadership, fostering the careers of others, and making services available to those with no means to pay;” the Division 12 Award for Distinguished Professional Contributions to Clinical Psychology; the Division 42 Award for Mentoring; and other forms of recognition.

In 2008, with great regret and sadness I resigned from the APA. My respect and affection for the members made this a hard and reluctant

step. I respectfully disagreed with decisive changes that APA made in its ethical stance after 9-11. In my view, those changes moved APA far from its ethical foundation, historic traditions, and basic values, and beyond what I could in good conscience support with my membership. 9-11 cast all of us into a tangle of complex issues, dangerous realities, and hard choices. My decision to resign from APA reflected my effort to judge what was right for me. I respect those who saw things differently, held other beliefs, took other paths.

We can each give so much to each other and to our communities. Sometimes just a word or gesture helps someone to keep going, overcome a baffling obstacle, or see new vistas. An example: During that second year at Harvard I signed up for an advanced course in the med school. The first day I was already lost. The professor kept asking if we saw various structures in our microscopes. Everyone nodded yes, but I had no idea what he was talking about. I was too embarrassed to admit I couldn't see any of them. Finally I raised my hand and confessed. He looked at me a long time, then came down the aisle, put his hand on my back, leaned down to the floor, and plugged in my electronic microscope. Sometimes that's all it takes.

## **MELBA J. T. VASQUEZ, PHD, ABPP**

Dr. Melba Vasquez is in independent practice in Austin, Texas. One of the most exciting periods in her career was when she served as President of the American Psychological Association (APA, 2011). She is the first Latina and Woman of Color of 120 presidencies of APA to serve as in that role. Her theme for the 2011 APA convention was social justice. Her special presidential initiatives included examination of psychology's contributions to the grand challenges in society, including immigration, discrimination, and educational disparities; three very hard-working task forces produced the reports:

- *Crossroads: The Psychology of Immigration in the New Century* (APA, 2012);
- *Pathways to a Better America: Preventing Discrimination and Promoting Diversity*, (APA, 2012);

- *Ethnic and Racial Disparities in Education: Psychology's Contributions to Understanding and Reducing Disparities* (APA, 2012).

Dr. Vasquez also served a term on the APA Board of Directors. She is a former president of the Texas Psychological Association (TPA) and of Divisions 35 (Society of Psychology of Women) and 17 (Society of Counseling Psychology) of the APA. She is a co-founder of APA Division 45, Society for the Psychological Study of Culture, Ethnicity and Race, and of the National Multicultural Conference and Summit. She is a Fellow of 11 Divisions of the APA and holds the Diplomate of the American Board of Professional Psychology (ABPP). She obtained her doctorate in counseling psychology from the University of Texas at Austin in 1978. Before becoming a psychologist, she taught middle school.

She currently serves as Parliamentarian for the 2021 APA President Jennifer Kelly and served in the same role for the 2020 APA President Sandra Shullman. She is a member of the APA Needs, Assessment, Slating and Campaigns Committee (NASCC), and on the Board of Trustees of the American Psychological Foundation.

She is a coauthor of a monograph, *Multicultural Therapy: A Practice Imperative* (in press), and previously co-authored five editions of *Ethics in Psychotherapy & Counseling: A Practical Guide* (with Ken Pope). She is also co-author of *How to Survive and Thrive as a Therapist: Information, Ideas and Resources for Psychologists in Practice* (also with Ken Pope); and of the *APA Ethics Code Commentary and Case Illustrations* (with L. Campbell, S. Behnke, and R. Kinscherff). Dr. Vasquez has also published about 100 book chapters and journal articles in the areas of professional ethics, ethnic minority psychology, psychology of women, counseling and psychotherapy, and leadership. She has served on numerous editorial boards.

Dr. Vasquez has been honored with over 50 awards for distinguished professional contributions, career service, leadership, advocacy, and mentorship, some of the more recent include:

- the American Psychological Association President's Lifetime Achievement Award, 2020;

- the American Psychological Association Presidential Citation, 2017;
- the Leona Tyler Award, APA Division 17, 2015;
- Distinguished Elder, National Multicultural Conference and Summit, 2015;
- Distinguished Alumni, Texas State University, 2014; and the
- Raymond D. Fowler Award for Outstanding Contributions to APA, 2014.

She is married to Jim H. Miller, a big supporter of her career. She very much values the full support of her friends, colleagues, and extended family, including her stepdaughter, six siblings, and their families. She is grateful that despite having only elementary educations, both her parents were politically involved at the grassroots level, engaged in civil rights activities, and articulated a strong belief in and support for education. She appreciates that they guided her into productive, social justice advocacy all her life.

## **NAYELI Y. CHAVEZ-DUEÑAS, PHD**

Growing up, I had all kinds of hopes and dreams for my future, but they were limited by the reality in which I lived. My main dream was to one day have enough money to buy *tacos al pastor* [pork tacos] from the street vendors to feed all of my family and friends. At an early age I worked to help improve my family's finances and reach closer to my dream of feeding my loved ones. The work was taxing and despite constantly being exhausted, I always had enough energy to read. Reading was my escape. I read about my homeland, Michoacán, Mexico, land of the Purépecha people. I studied the history of Mexico, a place full of contrasts and contradictions. I began to learn how my people carry both the intergenerational trauma and the determination, hope, and will to fight for a better future. All in all, books became my best friends. I also learned from my mom, Delfina Chavez-Dueñas—my living book, my constant source of wisdom, support, and love. She would often say, *a dios rogando y con el mazo dando* [God helps those who help themselves], a proverb which she used to remind me and my nine



siblings of, that hope is about dreaming of something better while working to make it possible. My mom embodies hope in action—a hope that defies logic, a hope that propelled her to leave Michoacán and immigrate to the United States (US). My mom and books allowed me to imagine without borders and limitations.

Full of dreams and hope, I arrived at the US when I was seventeen. Back then my aspirations were simple—find a good job to continue helping support my family and eventually return to Mexico. However, destiny had different plans. My early experiences in the US awakened my curiosity about culture and people. I learned firsthand about the ways that immigrants are exploited and abused in the workplace. The humiliating and inhumane conditions I experienced while working in the factories of Chicago motivated me to stay in school and lean into my mother's teachings. Education, a path blocked for many Black, Indigenous, and People of Color, was the only way I saw of putting hope into action and helping create a better future for me and my immigrant family.

As I continued reading endlessly and pursuing my education in the US, I enrolled in community college after high school. This is where I took my first psychology course. At the time I did not speak English. In order to succeed, I audiotaped all my lectures, translated them into Spanish, and then memorized them in English. When I reviewed my translated notes and understood the material, I knew I had found something I would not get tired of learning about—cultural differences and people's inner life experiences. Two years later, I transferred to Southern Illinois University where I met Joseph L. White, PhD and Kevin O. Cokley, PhD. These two souls shaped my academic career and influenced my decision to pursue a PhD in Clinical Psychology—a dream that seemed unreachable for a first-generation immigrant college student from the land of the Purépecha people. Dr. White and Dr. Cokley modeled and taught me how to be a socially responsible scientist and a transformational mentor. Thanks to my mentors, my family's sacrifices, and my mother's prayers and wisdom, I became the first person among my nine siblings to graduate from high school, attend college, and earn a doctoral degree. These achievements fueled my determination to learn, write, work, and use my ancestor's inherited skills to help dismantle the

systems that oppress, dehumanize, and criminalize the hopes of Communities of Color.

Today, I am a professor, psychologist, scholar-activist, and mentor. I received a PhD in clinical psychology with a specialization in children and adolescents from the American Psychological Association (APA) accredited program at Southern Illinois University at Carbondale. Most recently, I had the honor of receiving the 2018 APA *Distinguished Citizen Psychologist Award*. I lead a specialization in Latinx Mental Health at The Chicago School of Professional Psychology where I guide students in becoming lifelong learners, critical thinkers, and agents of social change in their communities and beyond. I carry with me the lessons from my studies, the modeling from my mentors, and the wisdom my mother ingrained in me from moving across worlds. I now attempt to pass these gems onto my mentees so they can practice ethically and with a sense of self-awareness and justice.

My professional life has been informed by my lived experience as a Mexican immigrant woman of Indigenous descent who lives, learns, writes, and teaches across borders and cultures. Together, these experiences and complexities are the foundation of the work I do in the IC-RACE Lab (Immigration Critical Race And Cultural Equity) which I co-founded and co-direct. The mission of our IC-RACE lab aligns with Dr. Joseph L. White's legacy of producing scholarship that "promote a psychology that is for the people, by the people, and accessible to the people."

## **HECTOR Y. ADAMES, PSYD**

I am a mosaic of roots that shaped and taught me. I am a kaleidoscope of those who have come before me: my African ancestors, whose drumbeats are life sustaining, my Queer Siblings of Color, who have contributed so much to our intersectional liberation. I am Bache, my maternal grandmother, an eternal sanctuary who affectionately would say, "*iMuchachito mio, pa'lante siempre!*" [My little boy, keep moving forward, always forward!]. She has taken flight, but her stability, grace, humility, and warrior spirit are much alive in me. I am a walking investment of my working-class parents who did not have the opportunity to finish high school but who

deeply value education. They are some of the most brilliant and resilient people I know; people who have thrived against great odds. I am my siblings; I am my chosen family. This is me—my kaleidoscope.

Born in the Dominican Republic, I immigrated to the United States at the early age of five. I vividly remember landing in New York City on a windy February night with my mother after a bumpy Eastern Airlines flight. My face being touched by the coldness of winter for the first time. My lanky body gently being zipped up in a navy-blue one-piece hooded snowsuit by two men—my *papi* and *tio*. People around talked in English. The new language and faces were disorienting to me and my developing brain. Meeting my paternal grandmother, cousins, and *tias* for the first time. All strangers to me. New smells, tall pointy buildings, buzzing cars flooded my senses—a new kind of kaleidoscope. No trees in sight, no greenery, no rhythmic dancing blue ocean waves. Over the Throgs Neck Bridge, through the South Bronx, and into Manhattan we drove. Sowing new seeds in a Latinx enclave—Passaic, our new home away from *Quisqueya*, our sanctuary, my emerging role as a cultural broker.

Formally, I am the first in my family to attend college and earn a graduate degree. I received my doctorate in clinical psychology from Wright State University in Ohio and completed my pre-doctoral internship at the Boston University School of Medicine's (BUSM) Center for Multicultural Training in Psychology (CMTP). I also completed my postdoctoral clinical neuropsychology training at BUSM and the Bedford Veterans Affairs Hospital in Massachusetts. I honor my African ancestors, Queer Siblings of Color, and my family through my professional commitment to serving Communities of Color. I have served on APA's Committee on Ethnic Minority Affairs (CEMA) from 2017 to 2020, where I had the privilege to serve as chair. I have also held leadership positions in the National Latinx Psychological Association (NLPA). I co-founded and co-direct the IC-RACE Lab (Immigration Critical Race And Cultural Equity Lab) where we investigate and develop frameworks and interventions designed to promote and support the psychological wellness of Black, Indigenous, and People of Color. We also create and publish toolkits and resources in Spanish and English accessible to the public (see [www.icrace.org](http://www.icrace.org)). Currently, I am a Professor and at The Chicago

School of Professional Psychology, where I train and mentor graduate students in counseling psychology who are aspiring to be therapists. I have earned several awards including the 2018 Distinguished Emerging Professional Research Award from the Society for the Psychological Study of Culture, Ethnicity, and Race, a Division of APA and the 2020 Distinguished Star Vega Award from the National Latinx Psychological Association (NLPA).

Echoes of my experiences being in a foreign land and developing as an AfroLatinx Queer Immigrant reverberate in my role as a psychologist. Together, these experiences also guide my ethics—valuing curiosity, embracing questions, honoring differences anchored in social justice, and the unwavering belief in the transformative power of supporting others. Of all things I could have been, I'm so glad to be a psychologist, a profession where we meet and connect with strangers and believe in the potential of all the flourishing that can unfold.

Psychotherapeutic work is arduous—it involves leaning into difficult conversations often centering around pain, suffering, and trauma—and it is radical because it works. When I reflect on what we do as therapists, I envision strangers embarking on a mutual journey toward emotional knowing. Psychotherapy—a sanctuary space, so intimate, so magical, so fragile—and yes, a space for strangers to meet. My clients and I, each navigating our own history and existence, our internal kaleidoscope tilted by an external world—hopeful and dispiriting, joyous and wretched, free and burdened—wrapped together by an affective relational bond full of endless possibilities.

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